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WHAT INFLUENCES HELP-SEEKING IN MENTALLY DISTRESSED YOUNG ADULTS?

Lucy Ann Biddle

A dissertation submitted to the University of Bristol in accordance with the
requirements of the degree of PhD in the Faculty of Medicine.

Department of Social Medicine

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Abstract

Mental disorder is common amongst young adults and associated with many adverse outcomes. Data indicate young adults are particularly unlikely to seek help for distress but little attempt has been made to explore this.

A population survey of 16-24 year olds was conducted to measure probable mental disorder (GHQ-12) and help-seeking from various sources. The help-seeking behaviour of 23 survey 'cases' was explored in qualitative interviews.

Less than 30% of GHQ-12 cases had sought help and just 8.3% had consulted a GP. More female (34.8%) than male cases (21.8%) ($p=0.003$) had sought help due to their greater use of lay sources. Similar proportions had consulted a GP. GHQ score was the strongest predictor of help-seeking, particularly in males who had a higher threshold of severity for help-seeking. Past help-seeking and the perception of having a problem were also associated with help-seeking.

Interviewees polarised distress into the categories 'normal' and 'real'. Illness behaviour involved negotiating one's position within this framework. 'Real' distress was a stigmatised category of extreme distress. Crossing the threshold from 'normal' to 'real' was thought to initiate an irreversible status passage involving stigma and undesirable treatment. This created a cycle of avoidance in which various strategies were used to normalise distress and the threshold for 'real' distress was repeatedly shifted to further extremes. Help-seeking was thought to officially move an individual across the threshold and so was central to avoidance. Young adults' distress was easily normalised due to beliefs that they do not suffer 'real' distress. These made obtaining help difficult and presented risk of a further stigma – being accused of 'faking' distress. GPs were not perceived as an appropriate help-option for mental distress.

Findings confirm high levels of non-help-seeking amongst mentally distressed young adults and provide a grounding from which to begin developing interventions to tackle this.

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Hin1 A.M.L. Hin2

Mostly, I would like to thank Mum and Dad for giving me opportunity and their unflagging support. I dedicate this thesis to them.

Author's declaration

I declare that the work in this dissertation was carried out in accordance with the Regulations of the University of Bristol. The work is original except where indicated by special reference in the text and no part of the dissertation has been submitted for any other degree. Any views expressed in the dissertation are those of the author and in no way represent those of the University of Bristol.

The dissertation has not been presented to any other University for examination either in the United Kingdom or overseas.

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Table of Contents

Abstract	2
Acknowledgements	3
Author's declaration	4
Table of Contents	5
List of Tables	13
List of Figures	16
CHAPTER 1: THE CONTEXT: MENTAL DISTRESS IN YOUNG ADULTS	17
Introduction	17
Mental disorder in young adults – an overview	17
Epidemiology: prevalence and risk factors	18
Psychological 'distress' and symptoms	19
Mental disorder	19
Suicidal thoughts and behaviour	20
The iceberg of untreated mental disorder	20
Strategies for prevention	21
Tackling the iceberg	21
The traditional approach	22
The problem of non-help-seeking	25
Summary and study aims	26
CHAPTER 2: THEORETICAL APPROACHES TO HELP-SEEKING	28
Introduction	28
Approaches to the study of help-seeking	28
Models of health service use	28
The Socio-behavioural model	28
The health belief model (HBM)	32

Summary	34
Sociological illness behaviour theory	35
Summary	49
 CHAPTER 3: EMPIRICAL STUDIES OF HELP-SEEKING FOR MENTAL DISORDER	 50
 Introduction	 50
 Search strategy and methods	 50
Search results	51
 General population surveys	 52
Surveys of psychiatric morbidity and ‘any’ service use	52
Surveys of mental health-related service use by ‘cases’	53
The prevalence of help-seeking for mental disorder	54
Factors associated with help-seeking	60
Illness behaviour	68
Limitations of general population surveys	73
 Surveys of illness behaviour	 74
Surveys of ‘anti-depressive’ behaviours	75
Vignette studies	76
Sources of help and treatment	76
 Qualitative studies	 80
Lay concepts and definition of mental disorder	83
Pathways into care	84
Help-seeking barriers	85
Perceptions of help-sources	88
Summary and limitations	91
 Studies specifically of young adults	 93
University student surveys	93
Epidemiological surveys	94
The prevalence of help-seeking amongst young adults	97
Factors associated with help-seeking	99
Summary	101

Illness behaviour and qualitative data	101
Perceived need for help	102
Barriers to help, coping and preferred help sources	103
Qualitative data	103
Summary	104
 CHAPTER 4: STUDY DESIGN AND METHODS	 106
Introduction	106
Study design	106
Mixed methods	107
The pilot study	108
Quantitative Population Survey	112
Survey objectives and design	112
Sampling	113
Sample size	114
Questionnaire Administration	115
The questionnaire	117
Socio-demographic characteristics and social support	117
General health and psychiatric morbidity	119
Help-seeking	124
Exploring illness behaviour	125
Data management and analysis	125
Data preparation	125
Analysis strategy	126
Qualitative interviewing	127
Objectives and design	129
Theory and approach	129
Method of data collection	134
Sampling and recruitment	135
Recruitment	137
The interview	137
Interview topic guide	138
Assessing psychiatric morbidity	138

Ethical considerations	139
Data management and analysis	140
Transcription	140
Contact sheets and field notes	141
Coding	141
Presentation of data	143
Quality control	143
CHAPTER 5: FINDINGS FROM THE CROSS-SECTIONAL SURVEY	144
Introduction	144
Characteristics of the sample	144
Response rates	145
Non-response bias	146
Characteristics of responders	149
Psychiatric morbidity	150
Self-rated general and psychological health	150
Help-seeking	151
Characteristics of GHQ Cases	154
Morbidity characteristics of cases	154
Factors associated with GHQ caseness	155
Possible chronicity amongst ‘non-cases’	157
Recent help-seeking amongst GHQ-12 cases	158
The prevalence of help-seeking	158
Sex differences	160
Perceived need for help amongst non-help-seekers	160
Factors associated with help-seeking	160
Characteristics of help-seekers and non-help-seekers	161
Multivariable analysis of factors associated with help-seeking	167
Sex differences in help-seeking by GHQ cases	174
Sex differences in the characteristics of help-seekers	174
Multivariable analysis of factors associated with help-seeking in male and female GHQ cases	176

Help-seeking from a GP	176
Help-seeking from friends and family	179
Help-seeking in respondents with suicidal thoughts	181
The prevalence of help-seeking	185
Factors associated with help-seeking	186
Help-seeking from a GP and from friends and family	186
Regression analysis – any help-seeking	187
Summary	191
 CHAPTER 6: YOUNG ADULTS' CONCEPTIONS OF MENTAL ILLNESS AND HELP-SEEKING BEHAVIOUR	 192
Introduction	192
Characteristics of interviewees	192
Concepts of health, illness and mental distress	197
Concepts of mental distress	199
Mental illness – 'real' distress	199
'Normal' and 'non-genuine' mental distress	200
Distinguishing 'real' and 'normal' distress	204
An example: depression	205
Susceptibility to 'real' mental distress	207
Beliefs about help and help-seekers	208
Summary	211
Illness behaviour	211
Recognising and evaluating mental distress	211
Normalising distress	215
Rationalising distress	216
Extending the extreme criteria for 'real' distress	217
Outcomes of normalising for help-seeking	223
Meanings of help-seeking and avoidance of help	227
'Making distress real' - transforming the status of distress	228
Help-seeking as an irreversible status passage	230
Stigma	233
The stigma of 'real' distress (mental illness)	233

Other stigmas of help-seeking: weakness, badness and shame	237
The stigma of non-legitimate distress and help-seeking	240
Summary	244
CHAPTER 7: PERCEPTIONS OF HELP SOURCES	245
Introduction	245
The General Practitioner	245
Perceived appropriateness of consulting a GP	246
Association of the GP with physical complaints only	246
Association of the GP with 'illness' only	247
Perceptions about GPs' abilities and willingness to help	247
GPs' knowledge, skills and training	248
Incompatibility of the 'medical model' and evaluations of GP help	249
Beliefs about GPs' attitudes to mental distress	252
Experiences of GP help	253
Prescription medicine taking	254
Negative evaluations and affects on help-seeking	254
Positive accounts	257
Meanings of taking medicines for mental distress	258
Counselling	259
Perceptions of counselling of a source of help	259
Ambivalent evaluations of the 'actual' benefits of counselling	262
Negative meanings of counselling	263
Personal experiences of counselling	264
Samaritans and telephone helplines	264
'Need' associated with use of the Samaritans	265
Perceived limitations of helpline 'help'	266
The lay group	266
Appropriateness and availability of lay help	269
Evaluations of lay group help	273
Negative responses: dismissal and stigma	275
Summary and conclusions	278

CHAPTER 8: DISCUSSION	281
Introduction	281
Main findings	281
Existing literature and contributions of this thesis	285
Prevalence of help-seeking	286
Perceptions of help sources	287
Factors associated with help-seeking	289
Sex differences in help-seeking	290
Lay concepts and beliefs	293
Illness behaviour	295
Discussion of methods and conceptual issues	307
Reflections on the mixed methods approach	307
The survey	308
Response rate and sample size	309
GHQ misclassification	310
Limitations of a cross-sectional design	311
Summary	312
Qualitative interviews	313
Validity and reliability	314
Transferability	319
Constructing 'non-help-seeking'	320
Conclusions and implications for policy and future research	322
 Appendix 1: Pilot study recruitment letter	 326
Appendix 2: Pilot study information sheet	327
Appendix 3: Consent form used in pilot and main study interviews	328
Appendix 4: Case vignettes	329
Appendix 5: The study questionnaire	330
Appendix 6: Covering letter sent with questionnaire in survey	340

Appendix 7: Reminder postcard sent to survey non-responders (1st reminder)	341
Appendix 8: Reminder letter sent with second issue of the questionnaire to non-responders (2nd reminder)	342
Appendix 9: Interview recruitment letter	343
Appendix 10: Information sheet for interviewees	344
Appendix 11: Final interview topic guide	346
Appendix 12: Help services information sheet for interviewees	347
Appendix 13: Letter to GP issued for use by distressed interviewees	348
Appendix 14: Sample contact sheet used in qualitative analysis	349
Appendix 15: Summary of themes relating to interviewees perceptions of help sources	351
Appendix 16: Pictures drawn by respondents on questionnaires	352
Bibliography	354

List of Tables

Table 2.1: Key contributions to the sociology of illness behaviour	36
Table 2.2: Suchman's (1965) five 'stages of illness'	37
Table 2.3: Mechanic's model of 'Factors affecting the response to illness'	39
Table 2.4: Zola's (1973) 'Triggers to the decision to seek medical aid'	46
Table 2.5 Freidson's typology of lay referral system and predicted rates of utilisation ...	48
Table 3.1: Databases searched and search terms used	51
Table 3.2: Types of study and main areas considered.....	52
Table 3.3: The prevalence of total help-seeking for mental distress by cases	55
Table 3.4: Prevalence of help-seeking from informal sources.....	56
Table 3.5: The Prevalence of help-seeking from a GP for mental distress by cases.....	58
Table 3.6: The association of age with help-seeking in the past year amongst cases	61
Table 3.7: The association of sex with help-seeking amongst cases	63
Table 3.8: The association of help-seeking with number and strength of symptoms.....	66
Table 3.9: Factors showing association with help-seeking in cases with disorder.....	67
Table 3.10: Barriers to help-seeking reported in general population surveys	69
Table 3.11: Factors associated with perceived need amongst cases with disorder	72
Table 3.12 Main variations in study design across general population surveys.....	74
Table 3.13: Example of a depression vignette from Jorm et al 1997	76
Table 3.14 Help-sources endorsed, suggested, and preferred in vignette surveys of depression.....	77
Table 3.15: Qualitative studies of help-seeking for mental disorder.....	81
Table 3.15: Qualitative studies of help-seeking for mental disorder (cont.)	82
Table 3.16 Possible reasons for non-help-seeking suggested by qualitative studies	92
Table 3.17: Help-seeking behaviour of depressed students - O'Neil et al 1984.....	94
Table 3.18: Epidemiological surveys of mental distress and help-seeking in young adults/ adolescents	95
Table 3.18: Epidemiological studies of mental distress in young adults/ adolescents (cont.).....	96
Table 3.19: The prevalence of help-seeking in surveys of young adults/ adolescents	98
Table 4.1: Characteristics of pilot study interviewees	109
Table 4.2: Timetable of data collection	116
Table 4.3: Key characteristics of a qualitative approach	128

Table 5.1: Sample Characteristics	144
Table 5.2: Sociodemographic characteristics of responders and non-responders.....	147
Table 5.3: Summary of differences between early and late responders	148
Table 5.4: Characteristics of responders – overall and by gender	152
Table 5.5: Help sources used by all respondents – overall and by gender	153
Table 5.6: Characteristics of GHQ cases and factors associated with caseness	156
Table 5.7: The prevalence of help-seeking and use of specific sources by GHQ cases in the last 4 weeks	159
Table 5.8: Characteristics associated with any recent help-seeking in GHQ cases.....	162
Table 5.9: Characteristics associated with recent help-seeking from a GP in GHQ cases	164
Table 5.10: Characteristics associated with recent help-seeking from friends and family in GHQ cases.....	166
Table 5.11: Summary: characteristics associated with help-seeking($p<0.05$) in bivariate analysis.....	167
Table 5.12: Odds ratios of the association between GHQ-12 score and recent help-seeking amongst cases.....	167
Table 5.13: Odds ratios (unadjusted and adjusted for GHQ score) of factors associated with any recent help-seeking in GHQ cases.....	169
Table 5.14: Odds ratios (unadjusted and adjusted for GHQ score) of factors associated with recent help-seeking from a GP in GHQ cases	171
Table 5.15: Odds ratios (unadjusted and adjusted for GHQ score) of factors associated with recent help-seeking from friends and family in GHQ cases	173
Table 5.16: Factors associated with help-seeking after controlling for GHQ score.....	174
Table 5.17: Mean GHQ scores of help-seeking and non-help-seeking cases in males and females	175
Table 5.18: Mean GHQ score of help-seeking cases by gender.....	175
Table 5.19: Odds ratios (adjusted for GHQ score) of factors associated with help-seeking from a GP in the last four weeks by male and female GHQ cases	178
Table 5.20: Help-seeking from a GP: preliminary and multivariable analysis of factors associated with GHQ cases' help-seeking in the last four weeks adjusted for GHQ score.....	179
Table 5.21: Odds ratios (adjusted for GHQ score) of factors associated with help-seeking from friends and family in the last four weeks by male and female GHQ cases	180

Table 5.22: Help-seeking from friends and family: preliminary and final multivariable analysis of factors associated with GHQ cases' help-seeking in the last four weeks adjusted for GHQ score	181
Table 5.23: Characteristics of respondents reporting suicidal thoughts.....	183
Table 5.24: Characteristics of respondents reporting recent thoughts of 'taking their own life'	184
Table 5.25: The prevalence of help-seeking and use of specific help-sources by those with any suicidal thoughts and thoughts of taking their own life in the last 4 weeks.....	185
Table 5.26: Characteristics associated with help-seeking from a GP in respondents with suicidal thoughts	188
Table 5.27: Characteristics associated with help-seeking from friends and family in respondents with suicidal thoughts.....	189
Table 5.28: Odds ratios (unadjusted and adjusted for GHQ score) of factors associated with any recent help-seeking in respondents with suicidal thoughts	190
Table 6.1: Socio-demographic characteristics of interview responders.....	193
Table 6.2: Morbidity and help-seeking characteristics of male interviewees	194
Table 6.3: Morbidity and help-seeking characteristics of female interviewees	195
Table 6.3: Morbidity and help-seeking characteristics of female interviewees (cont.)	196
Table 6.4: 'Types' of depression described by interviewees.....	205
Table 6.5: Common beliefs about susceptibility to 'real' mental distress/ depression...	208
Table 6.6: Beliefs about the typical characteristics of help-seekers	210
Table 7.1: The incompatibility of the methods and treatments associated with GPs because of the perceived nature of mental distress	250
Table 7.2: Common objections and fears about taking medication for mental distress..	255
Table 7.3: Positive evaluations of counsellors as a source of help.....	261
Table 7.4: Interviewees use of the lay group as a source of help	268
Table 7.5: Reasons why the lay group may be unavailable sources of help	272
Table 7.6: Competing evaluations of lay group help.....	273
Table 7.7 Examples of negative lay responses to distress.....	278
Table 7.8 General 'non-help-seeking' beliefs.....	280
Table 8.1: Key strategies of normalisation adopted by interviewees.....	300

List of Figures

Figure 1.1: Filters on the pathway to care - Goldberg and Huxley	23
Figure 4.1: The geographic region covered by Avon Health Authority	114
Figure 5.1: Patterns of response to the questionnaire.....	146
Figure 8.1: Young adults' understandings of mental distress.....	294
Figure 8.2: Interviewees' illness behaviour: the 'cycle of avoidance'	296

CHAPTER 1: THE CONTEXT: MENTAL DISTRESS IN YOUNG ADULTS

Introduction

This chapter provides a contextual background to the thesis by describing data about the prevalence and significance of mental distress in young adults (16-24 years) and considering the importance of help-seeking for this distress. It concludes by specifying the study aims and providing a plan of the thesis.

Mental disorder in young adults – an overview

Mental disorder is a common and disabling form of ill-health¹⁻³. In 1998, mental disorders accounted for approximately 12% of all disability-adjusted life years (DALY) lost worldwide² and the WHO anticipates that major depression will be ranked as the second highest disease burden after ischaemic heart disease by 2020⁴. Mental disorder is the second most frequent cause of sickness absence from work in the UK⁵ and has an estimated economic burden of approximately £32.1 billion per year⁶. Mental disorder significantly impairs quality of life⁷⁻⁹, may increase susceptibility to physical morbidity^{3,10,11}, and contributes to the occurrence of suicidal behaviour¹⁰. The importance of promoting mental health has been recognised in recent NHS strategy documents – ‘Saving- lives: Our Healthier Nation’⁶, ‘The National Service Framework for Mental Health’¹² and ‘The National Suicide Prevention Strategy for England’¹³.

There are a number of reasons to focus on mental disorder in young adults. Mental disorder is common amongst young people and associated with significant impairment and disability, particularly in relation to work, education and social interaction, which may have long-term implications¹⁴⁻¹⁶. It is also recognised that this age period can be a turbulent time with many life events¹⁷. Mental distress is therefore an important health problem for young adults who as a group otherwise generally experience good health. As well as being significant in its own right, mental distress is also associated with a number of further adverse outcomes such as suicidal behaviour, drug and alcohol misuse, risk taking, behavioural problems, and school failure^{15,18-20}. Additionally, there is some evidence that levels of mental disorder in young adults are increasing^{15,17}. Suicide

rates in men aged 15-24 years have increased dramatically in recent decades while rates in older age groups have decreased and suicide has become the most common cause of death in men under 35 years¹³. Rates of deliberate self-harm in the young have also shown large increases over the last 20 years^{21,22}. Mental disorder in young adults is therefore a major public health problem. In recognition of this, young adults have been targeted specifically in national government strategies¹³ and voluntary sector campaigns²³.

Adolescence or young adulthood is also the time when many people experience mental disorder for the first time¹⁸ and prospective data suggest that such mental disorder tends to recur and continue into later adulthood²⁴ rather than being self remitting as commonly supposed. Young adulthood may therefore mark the beginning of a trajectory of distress. Such observations reinforce the importance of understanding young adults' responses to distress and of the need to establish healthy illness behaviours since these may be carried forward throughout adulthood. Despite these issues, as a specific group, young adults have been neglected in mental health surveys and other research^{18,25}. Research has traditionally focussed either on children (below 16 years) or all adults as a general population group. In other studies young adults have been merged with adolescents and children despite the obvious differences in maturation, life experience and changing circumstances. This mirrors difficulties of service provision and the split between paediatric and adult services²⁶.

Epidemiology: prevalence and risk factors

Estimation of the prevalence of mental disorder is hampered by a lack of consistency in what is measured. Researchers have applied varying measurement tools, diagnostic criteria and cut points to define a diagnosed 'case' along the continuum of mental symptoms. Significant variation also exists in the time frame considered – 'recent prevalence' can range from 'past week' to 'past year' – and in the disorders that are included within generic studies of mental disorder. Some studies measure symptoms but not disorder. Obtaining prevalence estimates for young adults has additional complications since the data are often merged with younger adolescents, or only part of the age range is included, though data can be extrapolated from general psychiatric morbidity surveys. Such complexity cannot be adequately described or unravelled in the brief overview that follows. This will focus instead on recent UK-based estimates, and

on studies specifically considering young adults, and will draw attention to risk factors that may be relevant to a young adult population.

Psychological distress and symptoms

Psychological distress in young adults in Australia^{18,27} and the UK²⁸ has been measured specifically in a small number of studies using the General Health Questionnaire (GHQ-12) which enquires about a range of mental symptoms and identifies 'cases' with probable minor neurotic disorder based on responses to 12 questions. GHQ caseness ranged from 14.9%¹⁸ to 27.7%²⁷ implying that as many as 1 in 4 young adults may suffer from psychological distress. The two studies with the higher estimates focused on a younger population (16-19 years²⁷ and 15 years only²⁸). The third study, which considers the range 16 to 24 years, also reported a higher prevalence for those aged 16 and 17 years, the rate for females aged 17 being as high as 31.1%¹⁸. Supplementing these data, a recent regional UK study found that nearly 1 in 2 females aged 16-24 years were GHQ-12 cases²⁹. A recent large-scale UK survey using a less stringent cut-off point for caseness (scores of 3 or more) than in these surveys of young adults (4 or more) reported GHQ caseness for adults aged 18 and above as 27%³⁰. Where this threshold score was used for young adults, the prevalence of distress was 33.6%¹⁸.

Mental disorder

The point prevalence of neurotic mental disorder amongst 16-24 year olds was estimated as 14.2% in the UK National Survey of Psychiatric Morbidity (2000)³¹ in which caseness was identified using a detailed diagnostic clinical interview – the CIS-R³². The prevalence for all adults was 16.4%. Young females had a higher prevalence of disorder than young males (19.4% female, 13.5% males). Similar prevalences are reported in other national surveys in the UK³³ and Australia³⁴, and in smaller scale surveys of young adults¹⁶.

Estimates of the prevalence of major depression/ depressive disorder (variously defined) in young adults are approximately 10% - 12.4% (past month)¹⁴⁻¹⁶ and 2.1% - 6.1% (past week)^{33 35 36}. The prevalence of disorder in young adults appears comparable to that of all adults, but lower than those of adults aged 35 to 54 years³¹. However, young adults have higher rates of substance misuse^{31 34 16} and higher comorbidity³¹. Comorbidity is described as a common feature of mental disorder in young adults¹⁴⁻¹⁶ and is associated with more severe impairment¹⁴.

The factors associated with psychological distress and mental disorder in the adult population include: being female^{31 37 29 30 35}; having lower social class³¹; living alone or as a single parent^{31 30 35 37}; being unemployed^{30,31 35 37}; being a student³⁰; having a low level of education^{31 37}; physical illness^{31 30}; and low social support³⁰. Factors specifically reported for young adults are: being female (a female: male ratio of 2:1 is commonly reported)^{14 25 15,16 18}; lower socio-economic status¹⁶; and adverse life events such as poor interpersonal relationships, problems relating to schooling, university or work and family breakdown^{25 17,38}.

Suicidal thoughts and behaviour

Limited population data are available regarding the prevalence of suicidal thoughts. Findings from the 2000 UK National Psychiatric Morbidity survey suggest that at any time approximately 2.3% of the population have thoughts of 'taking their own life', 3.8% express suicidal thoughts such as feeling 'life is not worth living', and those aged 16-24 years have a risk of suicidal thoughts 2-3 times greater than most other age groups³⁹. The factors associated with suicidal ideation are similar to those associated with mental disorder and include being female, being unemployed, and lacking social support^{33,39}. Suicidal ideation is also strongly associated with psychiatric morbidity^{37,39,40}.

Deliberate self-harm (DSH) is common amongst adolescents and is associated with mental disorder and increased risk of suicide^{22,41}. A recent review found the mean life-time prevalence of deliberate self-harm amongst young people to be 14% and in most studies prevalence was higher in females, though it also suggested that this is likely to be an underestimation as some studies are based on hospital presentations and many episodes of self-harm do not receive medical attention²². A recent large-scale UK survey of deliberate self-harm amongst those aged 15 and 16 years reported a prevalence of 7% in the past year and an additional 15% reported suicidal thoughts⁴¹.

The iceberg of untreated mental disorder

There is evidence of a large 'iceberg' of mental disorder – that is, morbidity existing in the community that does not reach medical attention⁴²⁻⁴⁴. While this exists amongst all adults, young adults are a group least likely to seek help (Chapter 3). This iceberg is apparent from a number of data sources. Population-based psychiatric morbidity surveys also gathering data on service use reveal that only a small proportion had

sought help or received treatment for their self-reported symptoms (Chapter 3). Psychological autopsy studies of suicide cases show low rates of service contact – less than 40% of suicides seeking help from their GP in the month prior to death⁴⁵. These figures are lower for young people⁴⁶⁻⁴⁸, estimates ranging from 18% in suicides aged 15–24 years⁴⁸ and 26% in those under 30 years⁴⁶. Only 12.6% of episodes of deliberate self harm reported by 15 and 16 years olds in a recent UK survey had resulted in hospital presentation⁴¹. Surveys of consultation patterns in primary care indicate that increases in mental distress, deliberate self-harm and suicide in young people have not been matched by an increase in mental health consultations - the number of young people consulting for mental disorder has changed relatively little in the last forty years⁴⁹⁻⁵¹. Similarly, a large discrepancy between the amount of distress and the number of GP consultations emerged in a UK study of 15-year-olds where general practice casenotes were compared with measures of self-reported distress²⁸.

Strategies for prevention

Prevention of mental disorder prevents many challenges^{52 53} though a variety of strategies are proposed including: attempts to address social and economic risk factors via structural and policy change^{1,25,30}; providing services for high risk groups, for example, counselling for those recently experiencing stressful life events⁵³; and improving service provision, access to services and equitable resource allocation⁶. Those specifically suggested for adolescent or young adult populations include: educating the general public about the level of distress experienced by young people, particularly in response to life events such as relationship breakdown²⁵; skills-based programmes focusing on communication, problem-solving, grief and conflict management²⁵; school-based emotional health promotion and mental health screening⁴¹; and improving youth mental health services¹⁸.

Tackling the iceberg

Reducing the iceberg of untreated disorder has also been postulated as central to the reduction of morbidity, however, until recently this has involved surprisingly little attention to help-seeking and interventions to promote this. The problem of the iceberg has been viewed from two opposing perspectives. Traditional approaches conceptualise this as a problem of detection and therefore of the GP. Alternatively, it is viewed as a

problem of non-help-seeking and therefore located with the disordered individual and their social context.

The traditional approach

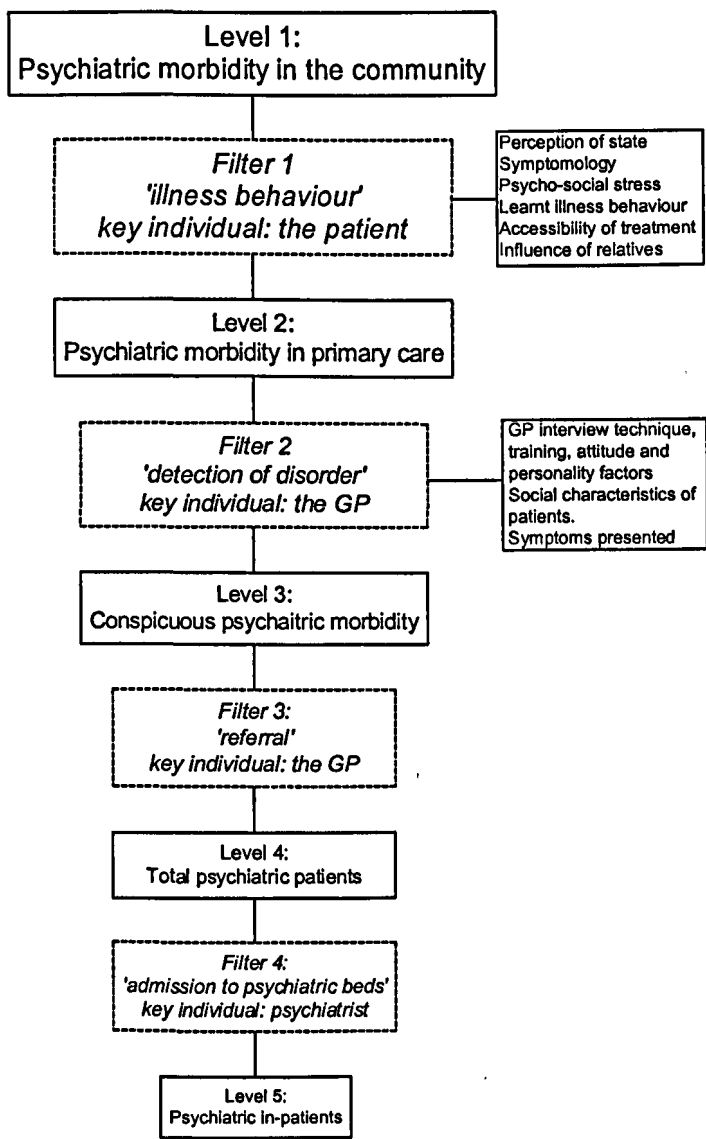
Those with mental disorder are more likely to be frequent attenders and mental disorder accounts for a large percentage of the morbidity encountered in primary care^{54 55}. The iceberg of untreated distress is therefore something of a paradox, which traditionally, has been accounted for by a high level of GP under-recognition of distress. It is estimated more than half the cases of major depression in primary care are unrecognised and that this is particularly the case where patients do not match GPs' common perceptions about depression^{56 57}, or somatise⁵⁸. Under-recognition has also been attributed to GPs lacking knowledge about depression and the necessary interpersonal skills to respond to the emotionally distressed^{7,57}. Much blame for the iceberg has therefore been attributed to the GP for failing to detect disorder. These arguments have also been applied specifically to young peoples' distress³⁸.

The context of this approach is the Goldberg and Huxley 'filters' model⁵⁵. This examines how disordered individuals move along a pathway to psychiatric care and why so few receive specialist psychiatric treatment. They describe a model with five levels and four filters (Figure 1.1). Each level refers to a different setting on the pathway to psychiatric care starting at the community and moving through primary care to secondary care. Filters represent the process of moving from one level to the other and are described as 'selectively permeable' in the sense that some individuals are more likely to pass through than others. The model describes the key factors constraining or facilitating movement at each filter. The numbers passing through each filter become progressively smaller accounting for the small proportion actually receiving psychiatric treatment.

The first level is that of the community and the total morbidity existing in the population. The first filter refers to which and how much of this morbidity presents to primary care. Goldberg and Huxley therefore describe the first filter as referring to *"those factors that determine whether a particular individual with distressing psychological symptoms decides to consult a GP"* and the patient and their illness behaviour is considered the crucial determinant. However, this is misleading since the first filter does not measure those who decide to consult for psychological symptoms but the proportion of individuals with psychological symptoms who consult a GP for *any* reason. It is

therefore regarded as a highly permeable filter with only a minority not progressing to level 2. The factors seen to determine this filter are physical access to services and cost, severity of symptoms, the experience of psychological distress, sociodemographic characteristics, and the issues of illness recognition and lay referral discussed by sociologists (Chapter 2).

Figure 1.1: Filters on the pathway to care - Goldberg and Huxley⁵⁵



Those passing filter 1 move to level 2 – that is, cases of mental disorder present in primary care - though Goldberg and Huxley note that most of these cases do not present with mental health-related symptoms. These cases are then subjected to a second filter passed by those whose disorder is detected in primary care. Despite recognising that patients’ modes of presentation vary and may be influenced by illness behaviour factors

and that likewise consultations have varying purposes, Goldberg and Huxley do not disentangle this and how it may influence movement through this filter. Instead, their focus becomes the behaviour and characteristics of GPs and the likelihood that these will allow detection of mental disorder. Factors discussed include the GP's concept of psychiatric disorder, their ability and accuracy in detecting disorder, personality and socio-demographic characteristics, interviewing skills, interest in psychiatry, and available time. The onus for passing this filter therefore is placed entirely on the GP.

Those whose illness is recognised move to level 3 – 'conspicuous morbidity in primary care'. In filters 3 and 4, Goldberg and Huxley then describe the processes by which these cases become 'selected' for secondary care.

Problems with the traditional approach

The primary purpose of the Goldberg and Huxley model was to make a case for the need to improve recognition and treatment of common mental disorders by GPs⁵⁹. Such thinking has resulted in the development of GP guidelines and training programmes to increase detection and improve doctor-patient interaction^{60,61}. This approach has also been applied to the iceberg of distress amongst adolescents and young adults where typically, much blame is allocated to health and other professionals, such as teachers, for not identifying distress or referring the young person to medical services¹⁹. This approach casts help-seeking and patient illness behaviour aside prematurely and provokes the claim that sociologists have 'lavished' attention on this somewhat inappropriately⁵⁵. There are two further key difficulties with this approach and research following from it.

First, it does not consider the reason for the patient in attending primary care. Level 2 is therefore composed of an undifferentiated range of cases with different illness behaviours, including those directly consulting with mental symptoms, through somatisers and patients using a 'ticket of entry' to consult hoping that their mental symptoms will be addressed, to those who by chance have cause to consult for a totally unrelated complaint but no intention of discussing mental symptoms. To regard all such cases as 'help-seekers' extends the definition of help-seeking beyond that which is meaningful. It also places unrealistic expectations on GPs as it conflates their abilities to detect with aspects of patient behaviour as reinforced by evidence that patients' presentational style are important influences on detection⁶² and therefore that illness behaviour is of central importance to the likelihood of passing filter 2. A more balanced

view attributes the problem of under-recognition to patients as well as the GP, recognising that failure to present with mental symptoms or disguised presentations are also problematic⁷.

Second, the assumption that most of those with mental disorder find their way into primary care or are frequent attenders needs to be challenged, particularly when considering young adults who in general tend to consult less frequently. While there is evidence from general population surveys to support the notion of increased general consulting by the distressed, even this suggests that less than 50% of cases attend primary care^{63,64}. Further, there is also evidence to the contrary. A recent UK study found that young people with psychological problems were not frequent attenders²⁸. Similarly, a recent UK psychological autopsy study of suicide cases found that GP detection was high amongst those who consulted (76%) but non-consultation (filter 1) was the greatest obstacle to treatment with 44% of suicides not consulting⁶⁵. This finding is supported by a further study⁶⁶ provoking the conclusion that prevention strategies need to focus on encouraging consultation. The same conclusions are drawn in relation to DSH⁴¹. While issues of GP detection and service provision are important, these will not benefit the significant proportion of individuals who do not attend. GP educational campaigns are ineffective without taking account of patient characteristics central to the study of help-seeking such as the type of treatment wanted and willingness to attend⁶⁷. The traditional approach therefore tackles the iceberg at the level of primary care only and not at the community level.

The problem of non-help-seeking

Alternatively, the iceberg is viewed as a problem of non-help-seeking. Studies ascertain which individuals with mental symptoms have sought help *for* those symptoms and regard other cases as 'non-consulters'. This is the standard approach of psychiatric morbidity surveys and the focus turns to understanding individuals' illness behaviour – mainly in terms of barriers to service use and using a socio-demographic approach (Chapters 2 & 3). There has been some – though limited – emphasis on issues relating to help-seeking when considering prevention. In relation to young people, this has involved suggestions including: educating young people and their parents about mental distress and the relevance of GP consulting for this²⁸, aggressive outreach¹⁵, and promotion of help-lines, self-referral agencies and school counselling services⁴¹.

Non-help-seeking for mental disorder is worthy of research attention for several reasons. The rate of non-help-seeking represents a high level of untreated morbidity and therefore suffering - a recent UK national estimate suggests approximately two thirds of adults with a mental disorder do not seek help from a healthcare professional³¹. This may increase or prolong social and personal costs as detailed above. Mental disorder can be highly treatable or otherwise amenable to resolution but untreated carries risk of various negative outcomes and comorbidity and, in the extreme, increased risk of suicide (above). Low rates of consulting prior to suicide indicate a need to explore reasons for non-help-seeking⁴⁷ and initiatives to promote help-seeking as a possible area for prevention. Those least likely to seek help (young men) are also those with the highest rate of suicide, and a lack of help-seeking has been suggested as a possible explanation for sex differences in suicide^{68,69}. While suicide represents the extreme end of the mental health spectrum, timely help-seeking for minor mental disorder may protect against crises being reached. There is also some indication that non-help-seeking in young people is associated with negative coping strategies such as DSH and alcohol use²². Understanding non-help-seeking for mental disorder may also suggest reasons why those who are suicidal do not seek help. Finally, recommended improvements to services and increased provision will be of limited benefit unless service use is also promoted. Non-help-seeking in young adults is of particular concern since responses to first episodes may be repeated throughout adulthood.

Summary and study aims

An overview of epidemiological data has revealed mental disorder to be a significant public health problem. Mental disorder is also a prevalent and growing problem amongst young adults (16-24yrs). A number of sources suggest a large iceberg of untreated mental disorder and there is some evidence that young adults are a group least likely to seek help. Despite such indications, it has also been noted that there is a lack of research specifically considering young adults. This study therefore sought to address this research gap and had the following main aims:

- To assess the prevalence of help-seeking for mental distress from a range of help sources amongst mentally distressed young adults (16-24yrs)
- To explore the factors associated with help-seeking amongst this group

- To gain in-depth understanding of the help-seeking behaviour of mentally distressed young adults and reasons why they may not seek help

The thesis is composed of eight chapters. Chapters 1-3 provide the background. Chapter 2 provides an overview of existing models of service use and sociological illness behaviour theory. This is followed by a detailed review of empirical studies of help-seeking for mental disorder in chapter 3. Four main types of study are identified and reviewed: general population surveys; surveys of illness behaviour; qualitative studies; and young adult surveys. Chapter 4 describes the study design and methods used. These were a quantitative cross-sectional survey of young adults and qualitative in-depth interviews with a sample of survey respondents.

Chapters 5 to 7 report the study findings. Chapter 5 focuses on the survey data and in particular on those respondents identified as 'cases' with probable mental disorder. It provides prevalence estimates of help-seeking from a variety of sources and describes factors associated with help-seeking from a GP and friends and family. Chapters 6 and 7 present the qualitative data. Chapter 6 provides details of interviewees' characteristics and then gives an overview of their concepts and understandings about health, illness and mental illness. This introduces their notion of mental symptoms in terms of a sharp polarity between 'normal' everyday distress versus 'real' mental illness and their beliefs about mental distress in young people. It then addresses how interviewees attempted to make sense of their own experiences of mental distress describing their tendency to normalise symptoms and their reluctance to enter the category of 'real' distress due to the status passage and in particular, the stigma associated with this. Chapter 7 considers respondents' evaluations of help in general and as provided by specific help sources - formal (GP, medication and counselling) and informal (Samaritans, friends and family). In the final chapter (8) the key findings of the thesis are reviewed and considered in the context of the existing literature. This is followed by a discussion of the strengths and limitations of the study. The thesis ends by considering the implications of the study findings, with a particular view to how these may be used to inform future interventions to encourage help-seeking.

CHAPTER 2: THEORETICAL APPROACHES TO HELP-SEEKING

Introduction

The previous chapter identified non-help-seeking for mental disorder as a public health problem. The next chapter (the main literature review) focuses on recent empirical data about help-seeking for mental disorder. Here, an overview of the main theoretical approaches to help-seeking is provided.

Approaches to the study of help-seeking

In the 1950s and 1960s, recognition of the illness iceberg (Chapter 1) provoked a vast investigative and theoretical literature. This literature was reviewed at the time of its greatest output⁷⁰ and recently in a selective review⁷¹, and has been categorised according to a range of disciplinary approaches: sociological, economic, geographic, socio-demographic, and socio-psychological. This chapter briefly considers: 1) models of service use – focusing on the use of formal health services and encompassing aspects of the economic, geographic (location and access), socio-demographic, and psychological approaches; 2) the sociology of illness behaviour which elucidates the socio-cultural and less quantifiable aspects of illness behaviour indicated, but not developed, by models of service use.

Models of health service use

A range of theoretical models has been developed to predict the use of health services. They propose a number of variables that may influence whether health services are used. A brief account and critique is provided here of the two most prominent models – the Socio-behavioural model and the Health Belief Model (HBM).

The Socio-behavioural model

The socio-behavioural model was conceptualised by Andersen (1968)⁷² and later elaborated upon by Andersen and Newman⁷³. More recently, it was again revised⁷⁴. It was devised in the US in a context of increasing concern about the availability of

sufficient and good quality healthcare for all sectors of the population. The principle driving the model was an attempt to attain an equitable distribution of healthcare services and this policy perspective informing its development is overt. It describes a range of factors said to predict service use and orders these into three broad types of determinant: societal, system, and individual. The exact role of each factor is said to vary according to the type of healthcare considered and the purpose of service use. The use of primary care for preventative care, for instance, is likely to be determined by different factors than the use of secondary care for acute illness.

Societal and system determinants

Societal determinants refer to the current state of medical knowledge and the prevailing social beliefs and norms regarding the definition and treatment of illness. Broad social trends are given as examples of these 'social norms' rather than lay beliefs about illness. These determinants are said to exert their effects by influencing 'system' and 'individual' determinants of service use but are accorded little attention in the description of the model. Instead considerable detail is focused on system determinants. These refer to: 1) characteristics of the healthcare system, such as the volume, distribution and organisation of formal healthcare resources in a given area or population, and 2) practical barriers that may impede an individuals' access to healthcare such as cost, waiting lists, and eligibility criteria for treatment. This focus reflects the model's concern with equity and treats the individual's desire for treatment as unquestionable.

Individual determinants

In addition to these structural factors, the socio-behavioural model also identifies characteristics of individuals that influence service use. These receive the most attention and are subdivided into predisposing, enabling and need factors. Taken together, these are regarded as forming the basis of individual's decisions about whether and when to seek help. Each set of factors can either facilitate or impede service use.

Predisposing factors

Based on the premise that some people use services more than others, the model suggests that there is a 'predisposition to service use' that differs across individuals. This predisposition is based upon 'individual characteristics' that predate and are independent of the illness: demographic characteristics such as age and gender; social-structural variables such as family size and occupation; and the individual's beliefs

about illness, doctors and treatment. It is stressed that these factors do not directly cause 'use' but create an inclination towards this, though there is little explanation of how they do so. Of these factors, Andersen and Newman conclude that demographic and social structure factors are of 'medium' importance while beliefs are of 'low' importance in influencing service use.

Enabling factors

Enabling factors focus heavily on access to healthcare. They refer to the means and opportunities available to pre-disposed individuals and those with 'need' to allow them to 'secure services'. These are therefore regarded as the factors that determine 'viability of action' and include mainly practical and structural access issues such as cost, time, and geographical location, and availability of services. Additionally, enabling factors encompass local knowledge or norms about healthcare and the existence of work or family responsibilities that may compromise service use. Andersen and Newman suggest this type of factor can be measured through family resources such as health insurance and income. Enabling factors allow direct measurement of issues surrounding equity and therefore have received much attention.

Need factors

The third set of factors relate to the individual's 'illness level' - that is, the nature of the illness and symptoms experienced. This determines 'need' and is postulated as the most direct determinant and a pre-requisite for service use on the basis that to seek help 'pre-disposed' and 'enabled' individuals must regard themselves as ill and in need of services. Perception of need is said to derive from an evaluation of the symptoms experienced, which may be influenced by predisposing variables (such as one's attitude and knowledge about health) and the actual physical, social and psychological impact of symptoms. It is suggested that two types of need can be measured - perceived and evaluated. Perceived need is intended to take account of the individual's experience of illness and self-perceptions of health, while evaluated need is described as an 'objective' standard of need for services judged by an expert medical panel. Absence of service use where need exists is simplistically conceived of as an indicator of inequity in access.

Evaluation

The socio-behavioural model has been used widely in empirical research⁷⁴, particularly that investigating general service use to assess equity of access⁷⁵. It has also been used to

guide research investigating service use by those with mental disorder. Two points are notable: 1) empirical application has been limited to measuring quantifiable demographic, socio-structural and need variables while more subjective factors such as perceptions and beliefs are rarely tackled; 2) the model yields descriptive data but provides little explanation.

The term 'socio-behavioural' is misleading because there is a lack of development or operationalisation of the societal and individual determinants such as culture, attitude and belief, which are hypothesised to contribute to the 'pre-disposition' to service use. Instead, demographic and structural variables are used as proxy measures for these allowing the model to apparently incorporate them, while actually failing to explore or address them. Indeed, it is not clear exactly what these are proxy for other than a vague category of 'attitudes and beliefs' on the reductive assumption that aggregates of individuals will share the same illness beliefs by virtue of broad socio-demographic variables. Complex issues therefore become hidden in descriptive categories and speculative meanings can only be imputed retrospectively to associations generated by these variables.

Similar difficulties exist with the concept of perceived need which has been described as 'theoretically and operationally complex'⁷⁶ by those attempting to use the model. The individual's own evaluation of their symptoms and need is scarcely addressed by the 'objective' indicators Andersen and Newman recommend - days of restricted activity, self-rated state of general health, and symptoms reported from a checklist. The model therefore inadequately measures the relationship between individuals' perceptions of need and service use⁷⁷, or the process of perceiving need. As most variance is explained by 'objective need', the model appears to explain little other than the self-evident observation that those with health problems are more likely to use services.

Andersen and Newman suggest that the model can be used as 'a guide in the selection of relevant variables' for use in analysis⁷³. In this sense, it appears to provide a methodological framework to structure quantitative data collection and analysis, rather than a theoretical framework to interpret findings and provide explanation. The theoretical content contributes little - essentially, that individuals with a 'need' use health services as long as they are predisposed to and have the access to do so. However, this rests upon a vague notion of need and how it can be measured, an incomplete notion of 'predisposition', and a deterministic focus on structural factors acting upon

individuals. The variables included under 'enabling factors' demonstrate this focus, the desire to measure access diverting attention from social issues and the role of social action and interaction in shaping illness behaviour. The model therefore produces descriptive data on patterns of service use rather than explanation or in-depth understanding of the dynamics of individuals' help-seeking.

The health belief model (HBM)

The HBM was first described by Rosenstock in 1966⁷⁸. It was initially formulated to explain health behaviours such as compliance and up-take of preventative services but was extended to encompass help-seeking for ill-health. It originated with a critique of the quantitative nature of the research into health behaviour that had preceded it, with the aim of advocating a more qualitative model that could set out to *understand* behaviour. In contrast to Andersen's structural determinism, the underlying premise of the HBM is that health care utilisation emerges from individual decisions and subjective health considerations and that motivation is the prerequisite for perception and action. The HBM derives from health psychology and limited empirical data. Sociological insights (below) were not incorporated into the model on the basis that these tackle *illness* rather than *health* behaviour, the latter being the area of concern at the time of the model's development. The extent to which the model can actually provide understanding of illness behaviour therefore is questionable.

The HBM outlines four sets of variable that influence an individual's health behaviour: 1) readiness to act, 2) the perceived risks and benefits of using health services, 3) modifying factors, such as age and gender, 4) cues to action. These variables represent a process where individuals assess and evaluate the risk of poor health, consider barriers and the costs and benefits of consultation, and subsequently, are motivated to act. When applied to illness behaviour, this process is set in motion in response to the occurrence of symptoms. The individual must first perceive and evaluate this condition and then consider possible courses of action. This perception and evaluation is guided by the individual's beliefs about the symptomology and available medical services, and modified by individual characteristics such as socio-demographic factors. Perception of the illness (readiness to act) and belief in the efficacy of action results in a 'propensity to act' which is held in balance until a cue occurs initiating action.

The 'propensity to act'

The HBM's main focus is on the variables leading to propensity to act: 'readiness to act' and 'belief in the efficacy of action'. These derive from health beliefs and perceptions.

Readiness to act

Readiness to act is influenced by general health beliefs and also specific beliefs relating to the symptoms experienced. These beliefs are subsumed by two variables: perceived susceptibility and perceived seriousness. Perceived susceptibility refers to the individual's subjective beliefs about their personal vulnerability to illness and, applied to illness behaviour, the belief that one is ill. High attenders are depicted as those who perceive themselves as vulnerable, and low attenders as those displaying less concern about illness. Perceived severity takes account of the intensity, frequency and believed seriousness of symptoms. It is suggested that the greater the perception of severity, the more likely the individual will use services. Perceived severity is distinct from actual severity though the two frequently coincide. There is lack of clarity about the origins of this perception, though it is linked to 'emotional arousal' and anticipated disruption likely to result from illness.

Belief in efficacy of action

Propensity to act is also said to involve belief in the efficacy of action, which derives from the individual's rational assessment of the benefits, costs and barriers to taking action. A belief in efficacy occurs where few barriers are perceived and/or benefits outweigh the costs of action. The reverse situation motivates avoidance. Potential costs and barriers cited are financial and practical such as loss of time, physical access to services; and perceived negative outcomes of treatments such as pain while benefit refers to belief that treatments will reduce susceptibility or seriousness of illness. Rosenstock argues that this will differ from objective fact about efficacy and is likely to be shaped by the individual's social group. Others suggest that perceived benefit of medical care is influenced by the individual's consideration of whether their own ability to cope and self-care is likely to be efficacious⁷⁹.

Modifying factors and cues to action

Propensity requires a cue to translate into action, the size of which will vary according to the level of propensity that has been reached. Cues can include knowledge of someone

else with the condition, perception of symptoms, or media campaigns, though Rosenstock believed the actual importance of such cues on determining behaviour could be hard to assess empirically. Modifying factors are incorporated on the basis that health beliefs are not equally distributed across the population but patterned by variables such as social class, hence accounting for socio-demographic patterning in service use data. Revisions to the model have added a range of additional modifying factors, such as the quality of doctor-patient relationship, personality variables⁸⁰ and cues, such as social influence^{79,80}.

Evaluation

The HBM model has also been used extensively but suffers similar limitations to the Socio-behavioural model. As it was not intended to address issues of help-seeking it is not surprising that concepts such as 'perceived susceptibility' and 'perceived severity' are inadequately explained and conceal a great deal of complexity. Like the Socio-behavioural model, the HBM implies an important role for beliefs and social processes but Rosenstock admits 'nothing is known about the genesis of the beliefs, nor the conditions under which they are acquired', despite implying that these drive behaviour. Proponents of the model have explored perceived susceptibility and severity in quantitative terms and using psychological traits such as 'locus of control', thereby diverting attention away from elaborating upon processes of perception and the origins or context of beliefs and instead adding an element of psychological determinism⁸¹ and offering descriptive rather than explanatory findings.

Summary

Models of service use have promoted a quantitative and descriptive approach to exploring help-seeking. They measure factors associated with service use but do not clarify the process of help-seeking and cannot take account of the purposeful action or meanings behind illness behaviour⁸². They are concerned with service use in general rather than in response to specific episodes of ill-health and so cannot consider how illness characteristics or the context within which illness occurs may influence utilisation. This omission could be particularly problematic if applied to mental health where the illness process itself may alter perceptions of need and self-worth. Nevertheless, both the models reviewed do identify similar areas of importance – namely, that individuals' perceptions of illness and need influence help-seeking, but that

other factors intervene between these perceptions and service use. The models also imply that social factors and beliefs may shape some of their key variables though what these are and how they are transmitted is not explored. This suggests that real understanding of illness behaviour may lie with analysis of the processes of perceiving and conceptualising illness and the role of social factors and belief, which in turn directs towards the sociology of illness behaviour. The only real explanation for non-help-seeking within these models is in terms of 'barriers to care' which are largely couched as practical factors restricting opportunity.

Sociological illness behaviour theory

The sociological study of illness behaviour refers to the attempt to understand how people make sense of and evaluate symptoms and illness, how they respond to these interpretations, and the role of social factors in shaping their responses. The field has developed over more than fifty years amassing a large literature composed of varying themes and theoretical perspectives⁷¹. The term has been used broadly, encompassing ever-increasing subject matter and phases of the illness trajectory from being becoming ill, through seeking help and doctor-patient relationships, to recovery and rehabilitation^{83 84}. There have been several attempts to review this literature, but these are generally dated^{85 70 86 87} and selective due to the vast quantity of publications^{85 70 71}. As noted in a recent review⁷¹, there have been no attempts to provide a comprehensive review of illness behaviour literature in the last thirty years. Only a brief overview identifying key contributions and main themes relevant to help-seeking is possible here. These are charted over time in table 2.1.

The beginnings of the sociological study of illness and illness behaviour are usually located with Parsons' concept of the 'sick role'⁸⁸⁻⁹⁰. This provoked much criticism and discussion establishing a number of issues for sociological enquiry, which were addressed by later theorists and became central illness behaviour themes. As such, Parsons' contribution can be regarded as a catalyst for the sociological study of illness behaviour alongside social and epidemiological surveys demonstrating the existence of a significant illness iceberg^{71,91}. It was noted that entry into the sick role was not as straightforward as implied and the concept 'illness behaviour' was introduced by Mechanic and Volkart in 1960⁹² to address this complexity, and shifting the focus away from Parsons' interest in doctor-patient relationships to a focus on patient behaviour.

Table 2.1: Key contributions to the sociology of illness behaviour

Date	Contributor	Themes introduced
1951	Parsons ⁸⁸	Introduced the sick role - a social role entailing rights and obligations including the duty to seek medical help. Criticised heavily for various omissions including description of the process of perceiving symptoms and help-seeking decision-making, socio-cultural variation and recognise possible conflict between patient and doctor and outcomes of this such as non-help-seeking and non-compliance.
1952	Zborowski ⁹³	Study revealing socio-cultural variations in perceptions of symptoms.
1960	Mechanic & Volkart ⁹²	Introduced the term 'illness behaviour' to refer to: 'the way in which symptoms are perceived, evaluated, and acted upon' and emphasising that this pre-dates the medical encounter and determines whether treatment takes place at all.
1965	Suchman ⁸⁴	Conceptualised illness behaviour as a trajectory by outlining 5 stages of illness each involving specific decisions and actions (Table 2.2). Discussed role of lay group in legitimising illness and directing response.
1965	Mechanic ⁹⁴	Referred to the need to consider importance of the 'meaning' of help-seeking when trying to understand help-seeking decisions.
1966	Zola ⁹⁵	Study of socio-cultural variations in perception of and response to symptoms.
1968	Mechanic ⁹⁶	Defined 10 factors affecting the response to illness (Table 2.3). Discussed 'normalisation', 'rationalisation', barriers to help-seeking and stigma.
1970	Freidson ⁹⁷	Introduced concept of 'lay referral system' that legitimises (or not) illness and prescribes courses of action (Table 2.5). Theorised that the degree of conflict/ incongruence between doctor and patient determining likelihood of help-seeking. Discussed illegitimate/ stigmatised illness and illness behaviour.
1973	Zola ⁹⁸	Described 5 triggers to help-seeking varying in importance according to social/cultural groups (Table 2.4).
1976	Dingwall ⁸⁶	Focused on how symptoms are interpreted and assigned meaning and described illness behaviour as social action in response to these meanings. Suggested illness behaviour could be a cyclical process. Re-directed illness behaviour research to the study of lay theories about illness.
1992	Pescosolido ⁹⁹	The need to consider help-seeking as a dynamic, on-going process and sequence of choices. Argued for central role of social networks in interacting between the individual and wider social structure to shape illness behaviour.

Table 2.1 demonstrates a shift in approach⁷¹. Early interest in illness behaviour was often 'individualistic', 'behaviourist' and centred around individuals' abilities to *recognise* illness^{86,97,99}. This was criticised as a bio-physical approach based on taken for granted 'medical' definitions of illness where lay inability to *correctly* detect illness was given as an explanation for non-consulting^{86,97}. Later approaches turned to examine the social construction of illness and social meanings attributed to symptoms in order to understand illness behaviour as social action and as an interactive process shaped by social networks⁷¹. This also entailed calls for a movement away from statistical work and attempts to establish 'laws' of behaviour, to a qualitative focus on the content of lay theories and the meaning assigned to diagnoses⁸⁶. Key theorists bringing about this shift were Freidson⁹⁷, Dingwall⁸⁶ and more recently Pescosolido⁹⁹.

Sociological models and conceptualisations of illness behaviour

A structured account of the issues and factors surrounding illness behaviour was provided by Suchman in 1965⁸⁴, who delineated a sequence of five critical phases involved in being ill and responding to illness (Table 2.2). These range from the experience of symptoms through formal help-seeking, to recovery and each involve a particular decision and action. This was one of many similar models characterising the literature at the time and conceptualised illness behaviour as a process or ‘career’⁷⁰. It also drew attention to phenomena such as denial of illness, delay in help-seeking, lay management of symptoms, patient ‘shopping’ between help sources, and lay group influence on illness behaviour ⁷¹, though it did not explore these in depth.

Table 2.2: Suchman’s (1965) five ‘stages of illness’⁸⁴

Stage	Decision	Actions
Symptom experience	That something is wrong	Recognition of illness Illness denial Procrastination
Assumption of sick role	That one is sick and needs professional care	Self-medication Lay validation
Medical care contact	To seek professional medical care	Shopping Delay
Dependent-patient role	To transfer control to the physical and accept prescribed treatment	Discontinuity
Recovery/rehabilitation	To relinquish the patient role	-

Suchman’s account had a limited empirical basis, derived from a study of help-seeking individuals with relatively severe physical complaints leading him to conclude that the process of illness recognition and help-seeking is generally unproblematic, and to the self-confessed limitation that “we do not know about those cases in the community which may require but are not receiving medical care” . Nevertheless, significance is attributed to Suchman for providing direction for further theoretical work and a schema for empirical research⁷¹.

Suchman’s model was closely followed by Mechanic’s seminal publication in 1968⁸⁶. Mechanic criticised other theorists on the basis that they had focussed on selected aspects of illness behaviour in ‘pick and mix’ fashion, and that this had limited understanding of help-seeking as a *process*. He also critiqued the strong focus on socio-cultural variation as a means of explaining illness behaviour arguing that this provided a broad picture but was less useful for understanding illness behaviour at the individual

level (eg. see Zola⁹⁵, below). His own approach was to view illness behaviour as a process of 'adaptation' in which the individual attempts to cope with their symptoms within the bounds of their knowledge, resources and social circumstances. He therefore suggested a "need to move beyond gross cultural and social differences in illness behaviour patterns towards the development of a social-psychological model". The resulting 'model' (Table 2.3) shares some similarities with the HBM model (above). It was derived from an examination of existing data and focuses on the illness, personal and social factors leading to 'differential identification, definition and treatment' of those who are symptomatic by the individual (self-defined) and those around them (other defined). Ten such factors are specified though it is noted that these are not exhaustive. Essentially, the model combines Suchman's stages 1-3, treating factors influencing perception of symptoms and the decision to seek help as the same and interactive. Mechanic states his model is applicable to physical and mental disorder, but in outlining many of the factors pays particular attention to mental disorder.

Table 2.3: Mechanic's model of 'Factors affecting the response to illness'⁹⁶

Factor	Detail
1. Visibility, recognisability or perceptual salience of deviant signs and symptoms	<i>Self-defined:</i> Visible or striking symptoms are more easily defined than those that cannot be detected directly, eg. those requiring diagnostic tests. There is a relationship between noticability of symptoms and delay. <i>Other defined:</i> Symptoms create social visibility of the person and their deviance which in turn initiates action.
2. Extent to which symptoms are perceived as serious	<i>Self-defined:</i> Individuals' less likely to perceive symptoms as serious and to seek help if they are familiar and the reason for the symptom and its probable course is known. <i>Other defined:</i> Deviations disregarded unless they appear dangerous to the individual or their family – then, they will be defined as sickness and the person will be brought for treatment.
3. Extent to which symptoms disrupt social context, eg. family, work and other social activities	<i>Self-defined:</i> Symptoms provoking social difficulties or affecting performance more likely to be defined and provoke help-seeking. <i>Other defined:</i> Others are more likely to initiate help-seeking if individual's behaviour/symptoms cause disruption, embarrassment, or inconvenience – eg. in the household or place of work.
4. The frequency of the appearance of signs or symptoms, their persistence, and recurrence	The likelihood of definition and help-seeking increases with the frequency and persistence of the behaviour or symptom – unless the symptom is very serious when just one occurrence would be sufficient for action. <i>Self-defined:</i> Those feeling persistently ill are more likely to seek help. <i>Other defined:</i> Frequently appearing 'deviance' more likely to be defined.
5. Tolerance threshold of those exposed to and evaluating the symptoms	Most symptoms ignored until a threshold at which illness is defined and help sought. <i>Self-defined:</i> Threshold influenced by values such as stoicism and culturally derived meanings attached to pain/ symptoms. Thresholds will also vary according to what the individual has become accustomed to. <i>Other defined:</i> Cultural groups differ in their tolerance of deviations. Differences also relate to family structure and social class. Uncontrollable, frightening or unpredictable symptoms are more likely to be acted upon.
6. Available information, knowledge and cultural understandings of the evaluator	Symptoms are recognised, defined and responded to differently according to the knowledge available to the evaluator. Knowledge includes understanding of bodily functioning, the meaning of signs and symptoms and whether these indicate a need for medical attention. This can influence help-seeking, uptake of preventative services and compliance with prescribed treatments. Knowledge can vary according to class and culture.
7. Basic needs which lead to autistic psychological processes	The tendency to deny illness as a coping strategy and in order to keep control. <i>Self-defined:</i> Fear and anxiety associated with particular diagnoses or medical procedures may result in a reluctance to seek help. <i>Other defined:</i> Illness may be denied because its consequences could be disruptive for the family, or because of its meaning for the family, eg. stigma.
8. Needs competing with illness responses	Illness is not necessarily central in the context of ones life. Other demands such as family responsibilities and cost may delay or prevent help from being sought if these take priority.
9. Competing possible interpretations that can be assigned to the symptoms once they are recognised	The normalising or explaining away of symptoms/ illness with other acceptable frames of reference. <i>Self-defined:</i> People attach meanings to symptoms with reference to their current life situation. This allows them to rationalise them as something other than sickness, eg. feelings of fatigue explained by working long hours. Some symptoms are more amenable to this than others.
10. Availability of treatment resources, physical proximity and psychological and monetary costs of taking action	Use and choice of help facility depends on access and convenience. Where barriers exist, alternative help sources will be selected, or a competing definition of the situation will be applied. In addition to costs such as time and money, barriers include stigma, feelings of humiliation and the cultural/ social accessibility of the help source, eg. degree of stigma implied by use of the service, consistency between patients' and providers' cultural framework for understanding illness.

Somewhat later, Dingwall (1976)⁸⁶, employing an interpretivist perspective, conceptualised illness behaviour as 'social action'. The starting point of this was a critique of Mechanic and other earlier approaches on the basis that these were positivistic, couched in a medical paradigm (above) and divorced from the interpretive processes confronting the individual and as such had not developed a concept of illness as a social phenomenon or provided an adequate explanation of lay perspectives and experiences of illness. Dingwall's argument was that the study of illness behaviour should focus on how experiences become organised into categories and assigned the label 'illness' and on the interplay of the individual and their lay network in this process of constructing illness (see also Chapter 4). This approach allows illness behaviour to be viewed as context-bound purposeful action deriving from assigned meanings rather than a deterministic response.

Dingwall formulated a model to illustrate this approach. This defines illness behaviour as the process of interpreting and making sense of 'deviations' that challenge the individual's notions of normal experience and formulating possible remedial actions to correct such deviations in order that the person may again "present himself to others as an essentially normal person". This involves a three-stage process:

- Evaluation of the problematic experience in the light of knowledge available to the subject
- The decision to act (based upon evaluation in phase 1)
- Monitoring of the effects of action.

The themes and stages of Dingwall's model therefore are not dissimilar to those introduced previously but the level of analysis differs - the primary focus being on 'ethnomedicine', ie. lay theories about illness. Dingwall recommended that research turn to examine this lay perspective and such endeavour is apparent in the literature¹⁰⁰⁻¹⁰². Dingwall also emphasises the complexity of pathways through these stages (particularly where lay involvement is incorporated) and the possibility that evaluation may be protracted. The model also allows for a potentially circular movement through these phases as new experience causes re-evaluation or unsuccessful actions require new approaches, which advanced the somewhat one-directional, static appearance of earlier models.

Provision of a more dynamic conceptualisation of illness behaviour was also the central aim of a more recent approach to help-seeking – Pescosolido's Social Organisation Strategy Framework (SOS)⁹⁹. Pescosolido conceptualises illness behaviour as a process of coping, managed through contact with others and entailing a complex and on-going set of strategies. People seek advice and treatment habitually and purposely from a multitude of sources – lay, professional, and semi-professional – until the situation resolves. She therefore argues that to understand illness behaviour, the whole episode (the career), not the single choice of whether to seek help from a medical practitioner, should be the focus of analysis. This means considering sequences and combinations of choices, decisions and actions during the career and examining their ordering, duration, how these relate and their social patterning. The choice to consult a medical professional is enmeshed within these wider patterns.

The SOS model posits the social network as the main unit of analysis, regarding this as providing structure and content (beliefs and values) within which careers of coping take place and by which they are organised, negotiated and constrained. The social network provides the backdrop for social interaction and therefore is the mechanism underlying social action. It is also shaped by the existing broader social structure, including the healthcare structure, placing contextual limits on choices and actions possible. The approach then combines notions of agency and structure to explain illness behaviour, which may serve to bridge the gap between individualistic and social models⁸² and essentially shifts focus to the processes of decision-making through social interaction, rather than determinants of a specific choice to seek help.

Detailed consideration of the major theoretical debates and schisms in the sociology of illness behaviour is provided elsewhere^{86,99} and is beyond the scope of this overview. Despite differing perspectives, there is also much consistency and continuity in the themes emerging from these models and these are instead outlined.

Symptom experience/ lay diagnosis

The process of perceiving, interpreting and defining symptoms is viewed as the crucial 'first step' in illness behaviour and essential to initiating the process of help-seeking^{84,86,95-97,103}. It was noted that the interpretation or 'meaning'^{86,97} given to a symptom will define 1) whether the problem is considered 'relevant to an illness model'; 2) whether it is serious enough to require attention; and 3) whether it is perceived as 'curable'⁹⁷. Interpretation therefore also determines the types of action taken in response,

including whether a doctor is considered an appropriate person to deal with the condition and hence whether help is sought^{86,96,97}. Several factors are discussed that may influence recognition.

Suchman⁸⁴, Mechanic⁹⁶ and Freidson⁹⁷ assigned an important role to the nature of symptoms and factors such as their visibility, frequency and perceived seriousness. They also noted the potential difficulty of insidious initial symptoms, which are therefore unlikely to result in illness definition even if serious^{84,96}. Mechanic expanded this discussion to consider the nature of mental symptoms such as those of depression that are not immediately visible and can be hidden by the sufferer and as such, unless discussed, are also less likely to be recognised and defined by friends or family^{96,104}. The extent to which symptoms interfered with usual activities was also found to determine interpretations - interference being a criterion for illness^{96,103}.

Zola⁹⁵, however, stressed the disjunction between symptomology and help-seeking behaviour and conceptualised the problem of lay diagnosis as a "socially conditioned selection process" based upon the values of cultural groups and the prevalence of the symptom within the given social context. He and Mechanic⁹⁶ argued that where a particular symptom is widespread it may be considered 'normal', 'inevitable' and 'part of everyday existence' rather than a sign of abnormality and therefore ignored or 'normalised'⁹⁶. Zola, in particular, also argued that symptoms and physical sensations such as pain are assigned differential meanings across cultural groups according to the values of that group, which may result in the same symptom being received and responded to with acceptance in one setting but concern and 'dramatisation' in another. Zola and others, notably, Zborowski (1952)⁹³, illustrated this perspective with empirical study of differing responses and attitudes across ethnic groups to essentially the same conditions. The clear limitation of this socio-cultural approach is its cultural determinism, which treats individuals as 'cultural dopes'⁸⁶ allowing no consideration of issues such as a motivated desire to deny symptoms. In contrast, both Suchman and Mechanic suggest that 'denial of illness' may be a feature of this phase resulting in a delay in treatment seeking.

According to Mechanic, Freidson and Dingwall, the crucial distinction is whether symptoms and experiences are perceived as 'normal' or 'deviant'. The process of recognising symptoms or interpreting the meaning of disturbances therefore involves comparing these with 'some standard of normality'⁹⁶ or 'theories of normality'⁸⁶. They

suggested similar factors that may be involved in this process - personal experience, acquired knowledge about health and illness, and social and cultural understandings, though Dingwall's account is considerably more elaborate since this is the central tenet of his theory. He argues that the process of lay diagnosis is based on lay theories about: the body, normal functioning and types of deviations that may occur; 'at risk groups' and types of situation associated with particular deviations; and the individual's own medical biography and vulnerabilities. These theorists also noted the importance of lay ideas about cause and responsibility to whether deviations were labelled as illness, observing that symptoms that can be rationalised are normalised as justified or understandable and hence accommodated – that is they make sense and so no longer challenge interpretative schemes. In fact, Mechanic argued that much deviance can be subsumed within a 'normal' frame of reference using alternative explanations until it is broken down by 'disconfirming evidence', and similarly, Dingwall describes a tendency for lay diagnosis to have a 'wait-and-see character', ie. suspension of judgement.

Of particular relevance to this thesis, Mechanic paid attention to lay interpretation of psychiatric symptoms. He argued this is particularly problematic due to a lack of knowledge about symptoms, the blurring between 'unusual personality traits' and mental disorder, and the ease with which mental symptoms can be normalised. He noted:

There is a strong tendency for relatives to normalise or explain away psychiatric symptoms...the maintenance of normal frames of reference is possible since many symptoms characteristic of psychiatric patients occur commonly among persons in the community who are not psychiatrically ill...such symptoms as restlessness, anxiety, depression and lack of interest in social activities are usually susceptible to a wide range of commonplace explanations and interpretations (pg152-3)⁹⁶.

These ideas had been demonstrated previously by Yarrow et al's¹⁰⁵ study of wives with mentally disordered husbands. The wives maintained denial of their husband's symptoms by normalising these in a 'vigil of resistance' or rationalising them to 'attenuate their seriousness' until this became impossible, which was usually at the point of hospitalisation, thus highlighting a process of negotiating and manipulating interpretations of symptoms.

Dingwall and Freidson's accounts provide explanation of why such behaviour may take place. They describe illness as social deviance and therefore as a value-laden term that implies need for correction and which may invite disapproval and disrupt social

participation. Conversely, normality implies social competence. The act of lay diagnosis therefore has a moral dimension and entails the imputation of deviance. Indeed, Mechanic suggested there is a strong inclination to normalise and rationalise mental symptoms due to cultural conceptions of mental illness and associated stigma.

Self-care, coping and deciding to seek help

Following on from lay diagnosis, models of illness behaviour turned to explore individuals' decisions about how to respond and varied actions adopted. Sociologists pointed out that seeking medical attention is only one of 'innumerable possibilities'⁹⁶ for coping with symptoms or distress. This observation is central to Pescosolido's emphasis on the 'career' because such an approach can reflect the plurality of options available while a singular focus on medical help-seeking, such as in models of service use, does not capture the realities of lay decision-making and the varied and multiple pathways that may be explored until the problem is resolved⁹⁹. Alternatives include various forms of self-care and self-medication, seeking informal advice or support, the use of 'alternative' medicine, attendance of self-help groups, and the decision to take no action – responses which have been discussed by later authors ^{82,83,106-112}. Dingwall emphasised that the actions adopted will be entirely derived from lay theories and meanings assigned to events.

The literature tends to suggest that individuals will attempt self-treatment initially and delay seeking help – doing so as a last resort or “upon final recognition that the interpretive possibilities that he has to hand are exhausted” and that “his sensations represent an unfamiliar experience for which he lacks the knowledge to set up immediate remedial action”⁸⁶. Mechanic conceptualised this as a 'coping dialogue' in which individuals' responses to illness reflect an attempt to cope with their condition while also negotiating the demands of everyday social life such as family and work responsibilities and the constraints imposed by various structural and social barriers. A failure to seek help is explicable partly by the conflicts they may face during this process. He (and later Alonzo¹¹³) argued that where symptoms are 'manageable' people have a tendency to ignore or accommodate these but as they become more severe, social factors and needs become less important and a decision to seek help is more likely.

Suchman's model⁸⁴ separates these initial decisions of how to respond and the perception of need for help (stage 2) from formal help-seeking decision-making and actual medical help-seeking (stage 3). There appears to be much overlap between these

phases in terms of the factors said to influence the decision involved, for instance: the nature of symptoms, conflicting demands of work or other social responsibilities, and lay referral (below), however, the separation of these phases is useful in making the basic observation that a perception of need for help does not guarantee that help will be sought or without significant delay.

This is evident from Mechanic's⁹⁶ and Freidson's⁹⁷ notions of 'barriers' to help-seeking, referring not only to structural barriers such as cost and physical access, but also social barriers such as stigma, which they and others¹¹⁴ discussed with reference to willingness to consult for mental illness. In such circumstances symptoms are more likely to be hidden or 'lied' about. Freidson in particular discussed the consequences of stigmatised illnesses describing these as 'illegitimate' forms of deviance, that is, 'unacceptable illnesses'. He argued: "of the corpus of illegitimate illnesses, we should expect the smallest proportion to reach consultation, given the shame and secrecy connected with them, and the ineradicable character of stigma"⁹⁷ since seeking help does not end the matter but leads to the assignment of stigma. Stigma also appears as an important factor in more recent examinations of illness behaviour^{115,116}. In this sense, both authors touched upon the *meaning* of seeking help for the individual, also addressed by other authors⁸³ - Freidson noting that naming something as illness has consequences independent of the biological condition, and Mechanic that, to understand help-seeking: *"it is necessary that we understand the influence of a variety of norms, values, fears and expected rewards and punishments on how a symptomatic person behaves"*⁹⁴.

The separation of need from actual help-seeking is also partly evident from Zola's approach⁹⁸. Zola argued that morbidity characteristics such as seriousness or degree of discomfort are not alone sufficient to provoke help-seeking and conceptualised help-seeking decision-making as a question of '*when* is help sought?' rather than '*why* is help sought (or not)?'. In a study of patients attending a GP with a 'new' complaint, he identified five 'triggers' that break an individual's ability to accommodate their symptoms (phase 2) thus causing them to seek help (phase 3) (Table 2.4). Zola's triggers reiterate the importance of non-medical factors in determining help-seeking, the cultural patterning of illness behaviour (as he found that the relative importance of each trigger varied by ethnic group), and the importance of the lay group in directing illness behaviour (below), but the account is limited by a lack of explanation of why individuals accommodate symptoms prior to the occurrence of a trigger and why the triggers

function as described - except to suggest briefly that triggers may in fact be 'excuses' to seek treatment.

Table 2.4: Zola's (1973) 'Triggers to the decision to seek medical aid'⁹⁸

Trigger	Operation
Occurrence of an interpersonal crisis	Event unrelated to the symptoms, for instance family bereavement, draws attention to the symptoms which provide a 'ticket' to a potential help source
Perceived interference with social or personal relations	Interference motivates help-seeking
Sanctioning	Another individual takes responsibility for making the decision that help should be sought/ gives permission for help-seeking
Perceived interference with vocational or physical activity	Interference motivates help-seeking
Temporalising of symptomology	The setting of external time criteria for the resolution of symptoms and seeking help if symptoms persist or reoccur beyond this deadline.

The decision to seek help also involves issues about whom to approach. Suchman⁸⁴ introduced the notion of 'shopping' to refer to the search for a help source that will provide a diagnosis and treatment compatible with the individual's lay understanding of their illness. In fact, choice of help source has received little attention but was most adequately addressed by Dingwall⁸⁶ for whom this issue was essentially linked to the process of evaluation and the meanings assigned to symptoms, since these meanings define who is viewed as an appropriate and competent help-source. Accordingly, Dingwall argued that interpretative schemes include "sets of socially licensed problem-solvers" perceived (often by lay consensus) to have specialist knowledge and hence the ability to provide aid. These may or may not be medical, and the individual may work through a 'hierarchy of resort', monitoring the effectiveness of suggested remedies and consulting further sources where others are ineffectual.

The lay group: caring, curing, legitimation and referral

The influence of the lay group on illness behaviour is widely acknowledged and has been of demonstrable importance throughout the illness trajectory, attributed with the roles of providing informal care and support to those who are ill, having a decisive input into lay diagnosis/ interpretation of 'symptoms', providing home remedies, legitimising illness and hence the validity of help-seeking, and directing, suggesting or 'sanctionning'⁹⁸ help-seeking or other action. However, many theorists were criticised

for merely paying 'lip-service' to this area⁷⁰. The lay group has received detailed attention from a smaller group of theorists, most notably Freidson⁹⁷.

Suchman perceived lay consultation to be the main and decisive aspect of whether a person came to adopt to the sick role and whether professional help-seeking is perceived as necessary (stage 2). More important than simply seeking advice, he described this as a process of the individual seeking confirmation and validation of their illness - essentially, the 'consent to be ill'. Based on his own study, in which three-quarters of his sample sought lay consultation, he concluded:

- Few people are confident enough to make decisions about the need for help alone and require *"the support and reassurance of others before they can recognise and accept illness and seek medical care"*.
- Lay consultation provides *"a functional and positive force toward the seeking of medical care"*.

Suchman's approach was based on help-seekers and therefore could not inform about situations where the lay group are a 'negative force' or do not provide legitimisation. This was addressed by Freidson⁹⁷ who developed the ideas in much greater depth. He argued that lay networks enforce particular views of illness and how it should be treated, which 'organise the direction of behaviour' by referring the individual to an agent or agency deemed competent to deal with the problem. Consistent with Suchman, he identified gaining lay approval and agreement that the complaints do represent 'illness' as central to this. Freidson introduced the concept of a lay referral system to encapsulate this effect and developed a typology of lay referral systems that he asserted could predict the likelihood of help-seeking according to two variables:

- 1) the culture and knowledge of the group and extent to which this is congruent with that of medical professionals - for instance, in respect to perception and definition of symptoms and the degree of seriousness imputed to these.
- 2) the extent to which the group is cohesive and will reinforce its culture on its members, or leave them free to make an individual decision about help-seeking without being subject to lay judgement.

Combination of these variables allows four types of lay referral system (Table 2.5). Where there is high congruence between lay and professional (medical) culture, help-seeking is most likely - especially where this is reinforced by a cohesive lay group. In

contrast, an incongruent culture is likely to discourage professional help-seeking as illness definitions imputed by lay and professionals may not match and there is scepticism or rejection of professional competence, though this effect will be partly diluted in a loose structure where the individual is more able to act independently without lay interference and to consult an 'outsider' from the group.

Table 2.5 Freidson's typology of lay referral system and predicted rates of utilisation⁹⁷

Lay referral system	Lay culture	
	<i>Congruent with professional</i>	<i>Incongruent with professional</i>
<i>Loose, truncated</i>	Medium to high utilisation	Medium to low utilisation
<i>Cohesive, extended</i>	Highest utilisation	Lowest utilisation

Freidson noted that the nature of the lay referral system may be modified by the illness experienced and focused particular attention on mental illness as a stigmatised condition. He argued that where illnesses are stigmatised, the lay group has low congruence with professional definitions. Therefore, he argued, in the case of mental illness, where not only the condition but also the use of treatment services is stigmatised¹¹⁴, there would be a considerable delay in help-seeking only reduced where lay networks were sufficiently loose and truncated to allow the individual to 'act privately', keeping this a 'secret' from others.

The extent of lay consultation and functioning of lay referral has been confirmed in recent empirical study¹¹⁷, but as a whole, the existing research literature is inconclusive and inconsistent and the actual affect on help-seeking behaviour debatable and diverse^{82,118}. In support of Freidson's typology there is some evidence that the relationship may be complex, dependent upon who is consulted, the condition, the population and the structure of the lay network^{82,106,111}. Some evidence also suggests that legitimacy may be more difficult to obtain in response to mental or emotional disorder¹¹⁹ or 'feelings' that cannot be demonstrated by an external sign of illness¹²⁰.

Pescosolido's⁹⁹ more recent discussion of the social network is somewhat critical of previous attempts that formulate the lay group as a predictor of service utilisation. She emphasises that social networks act as alternative 'caregivers', supporters and advisors, not merely referral systems, and drive the entire dynamic process of defining problems and exploring possible solutions, so cannot merely be 'brought into' theories as 'an item

on the individual's checklist for deciding on a single action' (ie. whether to seek medical help).

Summary

This chapter has provided a brief overview of some major theoretical approaches to help-seeking and relevant areas in the sociology of illness behaviour. It has charted a shift from static, individualistic or deterministic models focused on a single outcome (use of medical services), to more dynamic conceptualisations that view help-seeking as a process influenced by purposeful action and social networks and involving a series of decisions and attempts to cope. It was argued that models of service use provide mainly descriptive rather than explanatory data and are reductive in their operationalisation of complex variables such as 'culture' and belief. They have directed concern about non-help-seeking to the examination of largely practical and access-based barriers to health care¹²¹. In contrast, sociological approaches introduce notions of delayed or protracted help-seeking, coping, normalisation, incongruence and plurality of options. There is some indication that the meaning of help-seeking may be of importance to action, and stigma has been viewed as a consequence of mental health help-seeking, though there is little real explanation of what may motivate non-help-seeking. Although these approaches may be contrasted, there are also several generic themes that are agreed to be of importance to help-seeking: perception and evaluation of symptoms (lay diagnosis); perception of need; social factors and belief; the nature of symptoms; the lay group; and cues or triggers.

While models of service use provide schemas for empirical study, some sociologists have emphasised the methodological challenges of exploring the analytical potential of their insights^{86,96,99} – for instance, the difficulties of uncovering the 'taken for granted' such as the meaning of diagnoses⁸⁶. The next chapter reviews in detail recent empirical data about help-seeking for mental disorder. It will become apparent that these have more grounding in the models of service use and that in comparison sociological themes appear to remain poorly explored empirically.

CHAPTER 3: EMPIRICAL STUDIES OF HELP-SEEKING FOR MENTAL DISORDER

Introduction

This chapter reviews the empirical literature investigating help-seeking for mental disorder. This literature explores: the prevalence of help-seeking; factors associated with help-seeking; possible explanations for non-help-seeking; and some aspects of illness behaviour. The review examines data relating to all adults because of the lack of research attention directed towards young adults. The chapter also identifies methodological difficulties and current research gaps.

Search strategy and methods

A cursory glance at the existing empirical research in the area of help-seeking for mental disorder yields several observations. Many publications have emerged in recent years and findings from these have not, to date, been systematically reviewed. Interpretation of these is complicated by varying definitions of 'caseness' and help-seeking and the use of differing screening instruments. The data are frequently generated from generic surveys of psychiatric morbidity that did not examine help-seeking as their primary aim. There is also a notable lack of research concerned with young adults despite indications that this is a high morbidity but low consulting population group. In light of these observations, the search strategy took a broad approach in an attempt to synthesise an emerging but disparate field and to provide the context for this study of young adults.

The literature was searched using electronic and manual methods. A range of databases were searched (Medline, Embase, PsychLit and Web of Science) to ensure the search was not geographically limited and that literature could be accessed from the full range of relevant disciplines – psychiatry, epidemiology, and social science. Each database's thesaurus and referencing of previously identified papers in the area informed the selection of search terms to be used (Table 3.1). This process was particularly important for identifying appropriate non-sociological terminology to search for 'help-seeking' and 'illness behaviour'. Terms were selected to include all studies examining anxiety, mood, neurotic and affective categories of psychiatric disorder – i.e. common mental disorder.

This also incorporated ‘psychological’ and ‘emotional’ problems or disorders. Studies dealing specifically with psychotic illness, schizophrenia, personality, eating, or substance disorders were excluded as representing discrete areas of study likely to involve specific help-seeking issues.

Table 3.1: Databases searched and search terms used

Database	Mental Disorder	Help-seeking
Medline (from 1966)	Mental disorder, anxiety disorder, neurotic disorders, depressive disorder, affective symptoms, depression	Patient acceptance of health care, health services accessibility, primary health care utilisation, mental health services utilisation
Embase (from 1980)	Mental disorder, emotional disorder, depressive disorder, mood disorder, anxiety disorder	Health behaviour, health care utilization, patient attitude
PsycINFO (from 1967)	Mental disorder, major depression	Help-seeking-behaviour, health care utilization, health-care-seeking behaviour
Web of Science (from 1975)	Mental disorder, emotional problems, depressive disorder	Help-seeking behaviour, health-seeking behaviour, health services utilisation

Text word searching (.tw) was also used to improve identification of help-seeking literature and to search for help-seeking from non-medical sources. Words used included: help-seeking, illness behaviour, treatment seeking, barriers to care, informal help, service utilisation and self-help. All terms were combined using ‘or’ and ‘and’ functions. This strategy was supplemented by citation searching, hand searching of journals, and scanning the reference lists of retrieved papers and books.

Search results

A large number of papers were identified and abstracts were scrutinised to ascertain which were relevant. Studies dealing with specific population groups or categories (such as the elderly, children, the homeless, HIV/ AIDS suffers, trauma victims and ethnic minorities), or cultural settings likely to differ substantially from the UK were excluded as beyond the scope of the thesis. A diverse literature was retrieved and is organised in this review according to study type (see Table 3.2). The majority of data derives from epidemiological surveys focusing on adults of all ages. There is less consideration of illness behaviour, few qualitative papers, and few studies specifically of young adults. The chapter reviews studies of all adults first and then focuses on young adult data.

Table 3.2: Types of study and main areas considered

Study type	Main areas considered
<i>All adults</i>	
General population surveys	Prevalence of help-seeking Factors associated with help-seeking Illness behaviour: barriers to help-seeking, perceived need.
Surveys of illness behaviour	<i>'Anti-depressive' behaviour surveys:</i> Recommended coping behaviours Help-seeking options <i>Vignette surveys:</i> Recommended help sources Lay diagnosis and perceptions of need.
Qualitative studies	Lay concepts and definitions of mental disorder Perceptions of help-sources Help-seeking barriers and triggers Pathways to care
<i>Young adults</i>	
Young adult studies	<i>Student-based studies:</i> Characteristics of university counselling service users <i>Representative surveys:</i> Prevalence of help-seeking Factors associated with help-seeking <i>Illness behaviour</i> Perceived need, barriers to help and coping.

General population surveys

The largest group of studies identified are general population surveys. Typically, these are cross-sectional surveys of psychiatric morbidity, which also measure service use. They investigate morbidity and help-seeking at a community level and therefore identify those not in contact with services. There have been two main approaches. One body of literature looks at the extent to which psychiatric morbidity is associated with service use (for any reason) in the whole population but does not measure help-seeking for mental disorder per se. The second, recently dominated by national psychiatric morbidity surveys, looks specifically at help-seeking *for* mental disorder by those with disorder.

Surveys of psychiatric morbidity and 'any' service use

Several papers^{63,64,122-125} were identified which investigate the influence of psychiatric morbidity on the likelihood of using services for any reason amongst the general population and factors influencing which 'cases' are in recent contact with medical services. These follow the Goldberg and Huxley approach⁵⁵ described in chapter 1. They

do not consider the reason for service use but attempt to ascertain factors influencing filter 1, though they do this purely in relation to morbidity and socio-demographic factors rather than by examining illness behaviour. They report a strong association between psychiatric morbidity (usually probable disorder measured by GHQ) and service use - in some studies caseness appearing to double the probability of consulting for men and women^{63,64,122} - and estimate that approximately a fifth of GP consultations could be attributed to this. The same pattern of increased attending is also reported for those experiencing suicidal thoughts⁹. The association between psychiatric morbidity and service use increases with severity (increased GHQ score)^{64,122}. Cases are more likely to use services if they are female^{64,122,124}, older (30 years+)⁶³, or had physical illness⁶³. In one study GHQ score appeared to have the greatest influence on consulting in men aged 30-64 years, and male cases from lower social classes were less likely to seek help⁶⁴

These studies portray those with mental disorder as high service users, but they do not ascertain the reasons for these consultations and therefore do not inform about the extent or patterning of consulting *for* mental disorder (Chapter 1). However, they hint at complexities of help-seeking behaviour such as somatisation, repeat consulting for trivial complaints, and the possibility that physical co-morbidity increases consulting. They also suggest that, despite the increasing service use associated with psychiatric morbidity, between half¹²² and two thirds⁶⁴ of cases do not make contact of any sort with medical services and reinforce indications that young adults are less likely to consult.

Surveys of mental health-related service use by 'cases'

Most of the papers identified present epidemiological data from general population surveys about help-seeking for mental disorder by those screening as 'cases' with disorder^{29,31,34,35,37,126-163}. The majority relate to national psychiatric morbidity surveys conducted in the UK^{31,35,37,149,156}, Australia^{34,126-130,159,160}, Europe^{135,162}, Israel¹⁵⁷ and the USA^{136,141-145,148,150,153,161}. Many of these are multiple publications from a smaller number of surveys, sometimes focusing on a single disorder. The primary aim of these surveys was to obtain nationally representative data on the prevalence of psychiatric disorder to provide a sound basis for policy development rather than to examine service use, so little detailed information about help-seeking was collected. They have been conducted in the last 15 years and are designed to supersede studies of referred cases where diagnoses were unstandardised and untreated cases in the community were not

identified^{164,165}. To do this they employ standardised screening tools and screen large samples of the general population (in excess of 7000) to identify cases of morbidity. They are cross-sectional in design and report high response rates. The studies vary in the exact range of ages and diagnoses included in the category 'minor mental disorder'. They also employ differing diagnostic criteria and screening tools.

A smaller number of the papers describe the results of regional surveys in the UK²⁹, Europe¹⁵², Canada¹³¹⁻¹³⁴ and USA^{137-140,146,147,151,154,155,158,163} and New Zealand¹⁵⁵. These include urban, mixed, and rural populations. Most studies are cross-sectional but are of smaller scale than the national surveys. Two focus on women only^{147,163}.

The prevalence of help-seeking for mental disorder

Prevalence estimates of help-seeking by respondents identified as having mental disorder (hereafter 'cases') are summarised in Tables 3.3 to 3.5. Estimates from multiple publications are grouped together to avoid duplicate reporting.

The total prevalence of help-seeking for mental disorder

Table 3.3 shows estimates of the *total* prevalence of help-seeking for mental disorder by cases over either the six or twelve months preceding the survey. Data are presented from Europe¹³⁵, Australia^{34,126,129}, Canada^{131,134} and the USA^{136,145} but UK data are not available.

Two large-scale national surveys – from the Netherlands^{135,145} and the USA¹⁴⁵ – measure help-seeking from *any source* (ie. from health care, social care and informal sources such as telephone help-lines and support groups). They report that a quarter¹⁴⁵ and a third¹³⁵ of cases sought some form of help in the past year. However, neither study includes help-seeking from friends and family and so the true extent of informal, non-medical help-seeking is not represented.

The other papers quantify help-seeking from *any healthcare provider* incorporating all levels of care from general practice to specialist mental health services^{34,126,129,131,134,136,145}. These estimates suggest that around 20% to 40% of those suffering from mental disorder seek medical assistance for this disorder. The lowest rates of help-seeking (past year) were in the USA (17.3%)^{136,145} followed by Canada (25%¹³⁴-28%¹³¹) and the highest in Australia (32.5%¹²⁹-38%¹²⁶). Although UK estimates of help-seeking from any health source are lacking, UK estimates of the prevalence of GP help-seeking can be regarded as corresponding with estimates of help-seeking from any healthcare source since, in the

UK, GPs are a gateway to other health services. These estimates (35%³⁷ and 39%³¹, table 3.5) are very similar to the Australian data. While there may be differences in help-seeking according to setting, estimates are also likely to depend upon the definition of mental disorder used in each study – more stringent criteria yielding higher rates of help-seeking.

Table 3.3: The prevalence of total help-seeking for mental distress by cases

Study Characteristics*			Any source†	Any health care source	
Study	Diagnosis (tool)	Caseness (%)	Last year	Last 6 months	Last year
European Studies					
Bijl et al 2000 ¹³⁵ (Netherlands)	DSM-III-R (CIDI)	23.5%	33.9%		
Australian Studies					
<i>National Survey of Mental Health and Well Being</i>					
Henderson et al 2000 ¹²⁶	ICD-10 (CIDI)	17.7%			38%
Andrews et al 2001(a) ³⁴	ICD-10 (CIDI)	22.7%			34.6%
Andrews et al 2001(b) ¹²⁹	DSM-IV (CIDI)	13.4%			32.5%‡
Canadian Studies					
Bland et al 1997 ¹³¹	DSM-III (DIS)	31.2%			28.1%
Rhodes et al 2002 ^{134§}	DSM-III-R (UM-CIDI)	14.3%			25.0%
U.S.A. Studies					
<i>ECA Study</i> Shapiro et al 1984 ¹³⁶ (3 sites)	DSM-III (DIS)	19.2% 24.1% 20.3%		19.5% 15.6% 17.8%	
<i>National Comorbidity Study</i> Kessler et al 1999 ¹⁴⁵	DSM-III-R (CIDI)	30.8%	24.7%		17.3%

* All studies measure caseness over past year except Shapiro et al 1984 (past 6 months)

† Includes health care, social care, informal, but not lay sources – i.e. friends and family.

‡ Prevalence was 37.1% in DSM cases (past yr) reporting also symptoms in the past month – see Andrews 2001b

§ Includes mood and anxiety disorders only – substance abuse and antisocial behaviour excluded and analysed separately

Estimates for the prevalence of *any healthcare* help-seeking are also given in relation to specific disorders^{126,128,130-134,136-141,162,163}. These consistently report help-seeking to be most prevalent amongst those with affective disorders/depression (28.6%¹³⁸ - 52.5%¹³³ of cases past year, 27.7%¹⁴¹ - 37.1%¹³⁷ past six months) or suicidal ideation (64.4% past year¹²⁸) and least prevalent amongst those with substance abuse disorders (14%¹²⁶ -16.4%¹³⁴ past year, 7.9% -18.4%¹³⁶ past six months). These estimates show the same disparity between the prevalence of help-seeking in the USA and elsewhere – particularly Australia. Comparable UK data are not available.

Estimates of help-seeking from *any source* and from *any healthcare provider* are similar, suggesting that while informal and social care sources may act as additional sources of help, they are used infrequently as alternatives to medical care, though comparison between the two types of estimates is artificial due to inconsistencies in the categorisations of sources across studies, for instance, social sources such as social workers are included as ‘healthcare’ in Australian surveys.

Help-seeking from informal and lay sources

Few papers report on use of informal help sources such as self-help groups, telephone help-lines, alternative medicine therapists and religious leaders^{135,139,145,148}, and only one was identified that quantifies help-seeking from friends and family²⁹ (Table 3.4). Some authors indicate that relevant data were collected but do not report these and others group data about informal help-seeking with secondary social care services^{31,37}.

Table 3.4: Prevalence of help-seeking from informal sources

Study Characteristics			Past few weeks	Past year			Ever
Study	Diagnosis (tool)	Caseness (%)	Friends/ family	Any informal*	Self-help group	CAM therapy	Religious
U.K. Studies							
Somerset Morbidity Oliver et al, 2001 ²⁹	Mental distress (current) (GHQ-12)	33.5%	60-65% (exact % not given)				
Other European Studies							
Bijl et al 2000 ¹³⁵ Netherlands	DSM-III-R (past yr) (CIDI)	23.5%		10.4%			
U.S. Studies							
National Comorbidity Kessler et al, 1999 ¹⁴⁵	DSM-III-R (past yr) (CIDI)	30.8%		8.9% [†]	7.4%		
Kessler et al, 2001 ¹⁴⁸	Self-reported anxiety or depression (current)	9.4% (anx) 7.2% (dep)				20% (anx) 19.3% (dep)	
Pollard et al 1989 ¹³⁹	DSM-III Anxiety disorders (current) (ASI)	14.2%					1.5%

* Including practitioners of alternative medicine, healers, self-help groups, telephone help-lines, religious leaders but not friends and family
 † Does not include self-help groups (see adjoining cell) or alternative medicine, but includes the following formal social care agencies: social worker, nurse or counsellor provided in a social service setting.

There are two estimates of total informal help-seeking, though these exclude help-seeking from friends and family. They are both low – 10.4%¹³⁵ and 8.9%¹⁴⁵ but include

different groups of personnel and as such are distinct estimates with little comparability. USA studies consider help-seeking from specific informal help sources, though the quality of some of these data is poor: - self-help groups (7.4%)¹⁴⁵, religious (in a small scale survey with few cases) (1.5%)¹³⁹ and complementary or alternative therapists (in a study without formal diagnostic screening) (20%)¹⁴⁸. Unsupervised use of alternative medicine was much higher (approximately 55%). Similar use of alternative medicine is not evidenced elsewhere since this was included within the total estimate of informal help-seeking of just 10.4%¹³⁵. The one estimate of lay group help-seeking reports that as many as two thirds of cases sought help from friends or family²⁹ but this is a regional UK survey based on 'distressed' GHQ cases rather than those meeting formal diagnostic criteria for disorder as reflected in the study's high prevalence of caseness (33.5%).

Help-seeking from a GP

The literature pays particular attention to the prevalence of GP consulting and this is the main form in which UK data are presented. Estimates are given for *all* cases seeing a GP and for the proportion seeing a GP as the *only* source of professional help. The latter estimates derive from studies taking a hierarchical approach to service use that quantifies healthcare contacts in mutually exclusive categories that prioritise contacts with secondary care. They therefore exclude from their estimates of GP help-seeking cases in contact with both a GP and secondary care sources. These are primarily American studies reflecting the nature of the USA healthcare system where individuals are able to choose between sectors. This approach reflects an interest in individual's pathways through the healthcare system and structural constraints upon this including GPs' recognition and referral behaviour rather than the illness behaviour of disordered cases (help-seeking). This review focuses on estimates of the total proportion of cases seeing a GP (Table 3.5) since this thesis is concerned with how people seek help - not their subsequent pathways through the healthcare system - and these are most congruent with the UK context where the GP is the focal point of any attempt to obtain formal help.

Table 3.5: The Prevalence of help-seeking from a GP for mental distress by cases

Study Characteristics					
Study	Diagnosis (tool)	Caseness (%)	Past 2 weeks	'Past few weeks'	Last year
U.K. Studies					
National Psychiatric Morbidity Survey 1993 (Meltzer et al 1995 ³⁷ , Bebbington et al, 2000 ¹⁴⁹)	ICD-10 (CIS-R)	16% past week	7%*		35%
Somerset Morbidity Study Oliver et al, 2001 ²⁹	Mental distress (GHQ-12)	33.5% 'past few weeks'		20%†	
National Psychiatric Morbidity Survey 2000 ³¹	ICD-10 (CIS-R)	17% past week	6%		39%
Other European Studies					
Bijl et al 2000 ¹³⁵ (Netherlands)	DSM-III-R (CIDI)	23.5% past year			22.4%
Australia					
<i>National Survey of Mental Health and Well Being</i>					
Henderson et al 2000 ¹²⁶	ICD-10 (CIDI)	17.7% past year			29.4%
Andrews et al 2001(a) ³⁴	ICD-10 (CIDI)	22.7% past year			27%
Canadian Studies					
Bland et al 1997 ¹³¹	DSM-III (DIS)	31.2% past year			22.1%

* Includes 3% consultations for mental health only and 4% consultations for both physical and mental health reasons

† Exact proportion not given – reported as 1 in 5.

Table 3.5 shows estimates of the proportion of cases discussing mental health problems or symptoms with a GP from national psychiatric morbidity surveys in the UK^{31,37}, the Netherlands¹³⁵ and Australia^{34,126}, and regional surveys from Canada¹³¹ and the UK²⁹. Estimates of help-seeking in the past year range between 22.1%¹³¹ and 39%³¹ of cases, the lowest estimate also reporting a high prevalence of caseness (32%) therefore suggesting a possible lack of specificity in the detection of cases. The highest rates are reported by the UK national surveys where over a third of cases had 'spoken' to their GP about mental health concerns. This is a greater proportion than estimates of those seeking *any* help or *any healthcare* in surveys from other countries (above). The UK national surveys also measure GP consulting in the previous two weeks by current cases. These estimates are lower – 6%³¹ and 7%³⁷ but their short time frame may not represent GP help-seeking among chronic cases who do not see their GP on a two weekly basis. Surveys providing estimates for *any* or *any healthcare* help-seeking and help-seeking from a GP^{126,131,135} show

small differences between the two estimates suggesting that a GP is the most frequently consulted single source by those seeking help for mental disorder.

Disorder-specific prevalence estimates of GP help-seeking are also provided^{31,35,126-128}. These are highest for depression and suicidal thoughts. The prevalence of GP help-seeking by cases with depression/ affective disorder was 15% in the past two weeks³¹ and ranged from 40%¹²⁶ to 62%³¹ in the past year, with the exception of one paper³⁵ which reports a prevalence of 12.5% in the past year. This paper also reports an unusually high prevalence of current morbidity (25.5%) suggesting the study lacked specificity in its case screening and may have included a large number 'cases' unlikely to require medical assistance. The Australian national survey also reports that 36.6% with anxiety, 20.6% with substance disorder¹²⁷ and 50.5% with suicidal ideation¹²⁸ sought help from a GP in the previous year. All consultations were for mental health reasons, though whether the specific disorder was addressed is not recorded.

Help-seeking from secondary mental health services

Data on the use of secondary care are less relevant to this thesis and so are considered briefly. In the UK, secondary care use rarely occurs without GP referral. In the USA and Canada where GPs do not act as gatekeepers, these data may be more reflective of initial help-seeking choices but papers considering direct use of specialist care services in both settings found that in practice few individuals bypass primary care¹⁴². The 2000 UK National morbidity survey³¹ found that 16% of cases had used a secondary mental health service in the previous year. This estimate is similar to those obtained elsewhere^{129,135}, including the USA¹⁴⁵.

Summary

- Prevalence estimates of total help-seeking for mental disorder suggest that only a minority (approximately a third) of adults suffering from a mental disorder seek some form of help for this disorder.
- Most estimates exclude help-seeking from friends and family which may be far more extensive. There is an indication that use of other informal sources is small but again data are limited. The true extent of help-seeking from informal sources and friends and family is uncertain and is a key area of omission in the existing research literature.

- Rates of GP help-seeking are similar to those for total help-seeking suggesting GP help-seeking accounts for most of that reported.
- Help-seeking appears most prevalent amongst those with affective disorders and least amongst those with substance misuse disorders.
- The highest rates of help-seeking were reported in the UK where 39% of cases had sought help³¹. This was followed by Australia and Europe. USA rates are the lowest. Variations in estimates across studies may relate to differences in the definitions of caseness and help-seeking (pg74).

Factors associated with help-seeking

Most of the surveys also provide a quantitative investigation of sociodemographic and morbidity factors associated with seeking help for mental health problems from any healthcare professional or from a GP^{31,34,37,127-145,149-152,163}.

Papers investigate associations amongst either (1) the whole sample^{31,37,127-129,134,135,137,142-145,149-151}, or (2) the subset of the sample identified through screening as mentally disordered cases^{34,129-133,136,138-142,152,163}. These two approaches produce differing data. Whole sample analyses inform about factors associated with seeking help for mental health whether or not the respondent has a disorder. The findings may be confounded by differing patterns of mental disorder across social groups. Where analyses control for morbidity to avoid this confounding they measure factors influencing help-seeking amongst a general population with no attention to 'need' and so include some individuals without mental disorder. Although data suggest that only a small proportion of non-cases seek help for psychological problems, given the overall low prevalence of help-seeking, these form a considerable proportion of all consultations¹³¹.

In contrast, 'cases only' analyses inform about the likelihood of formally defined cases consulting according to the factor under consideration, but these analyses are often restricted because they are conducted with only a small proportion of the study population and have mainly been performed in the context of smaller scale regional and/or disorder specific studies¹³⁸⁻¹⁴⁰. The majority of papers describing 'cases only' analyses are dated and USA-based^{136,138-142}. UK data are not available. Here, most attention will be focused on 'cases only' analyses since these are of greater relevance in the context of this thesis, but as these are limited whole sample data are also referred to.

Sociodemographic factors

Socio-demographic characteristics investigated include: age, sex, education, marital and occupational status, income, social class, area of residence and household structure. Age and sex will be discussed in detail and other factors more briefly as these are difficult to interpret in relation to young adulthood.

Age

Investigations of the association of age with help-seeking have been carried out in surveys in the UK^{37,149}, the Netherlands¹³⁵, Australia¹²⁷⁻¹³⁰, Canada¹³¹⁻¹³⁴, the USA^{136-141,143,144}. With the exception of the UK data, which describe help-seeking from a GP, all papers consider help-seeking from a healthcare professional. Ten papers^{37,129,130,133,135-137,141,144,149} allow direct comparison of young adults (represented as 15, 16 or 18-24 year olds) with other age categories. Of these, five^{129,130,133,136,141} focus on cases only (Table 3.6).

Table 3.6: The association of age with help-seeking in the past year amongst cases

Study	Help-seeking from any healthcare source		
	Yrs	OR (95%CI)	
Andrews et al 2001b ¹²⁹ (ASMHWB, Australia)	Full data not given for cases only analysis		
Issakidis & Andrews 2002 ¹³⁰ (ASMHWB, Australia) (Anxiety cases only)	18-24	1.0	
	25-34	2.1 (0.8-5.3)	
	35-44	2.5 (0.6-9.7)	
	45-54	2.4 (1.0-5.8)	
	55-64	1.7 (0.3-9.5)	
Olsson & Klerman, 1992 ¹⁴¹ (ECA, USA) (Depression cases only)	18-24	0.6 (0.4-1.0)	
	25-34	1.1 (0.7-1.6)	
	35-44	1.3 (0.8-2.0)	
	45-64	1.8 (1.2-2.6)	
	65+	0.4 (0.2-0.7)	
	Yrs	% seeking help	% not seeking help
Lin & Parikh, 1999 ¹³³ OHS (Canada) (Depression cases only)*	15-24	15.7	27.1
	25-44	66.6	45.7
	45-64	17.8	27.1
		% seeking help	
Shapiro et al [†] 1984 ¹³⁶ (data reported for 3 sites) (ECA, USA)	18-24	11.0 – 12.7	
	25-44	17.3 – 24.1	
	45-64	20.2 - 21.9	
	65+	4.5 – 19.4	

* P<0.01
† Refers to help-seeking in past 6 months

‘Cases only’ and ‘whole sample’ analyses show a consistent pattern in which young adults appear less likely to seek help compared to those aged between 25 and 54 years, though ‘cases only’ evidence is weak (Table 3.6). The distribution of help-seeking in relation to age takes the form of an inverted U-shape. The likelihood of help-seeking

increases after young adulthood until the older age cohorts when the likelihood reduces again. The results of a further two 'cases only' papers are compatible with this pattern, one reporting an association between the likelihood of consulting and increased age at onset of morbidity¹³², and the second that help-seeking was most likely in those aged 36 or older (OR 3.3)¹³⁸.

Six papers present differing findings, two suggesting that service use is *more* likely amongst those who are younger^{127,131} and four reporting no age differences^{128,134,139,140}, but these differences may be explained by study design. Two of the papers^{128,131} use just two broad age categories for analysis (18-44 yrs and 45 yrs plus) which may obscure differences since the category of 'younger' respondents combines the groups that others identify as the lowest (18-24 year olds) and highest (25-44 year olds) consulters; a further two exclude respondents younger than 21 years^{139,140}; and three^{128,139,140} focus on specific diagnoses only, resulting in small sample sizes and therefore underpowered analyses.

Sex

An established finding in consultation and illness behaviour literature is the tendency for females to consult more than males to an extent that cannot be attributed solely to biological differences^{166,167}. This appears to be the case for minor illness and also psychosocial morbidity/emotional health¹⁶⁶⁻¹⁶⁹. Suggestions for these differences are that males restrict their help-seeking to physical morbidity, are less willing to discuss personal issues and less likely to recognise and label emotional symptoms^{168,169}.

General population surveys of psychiatric morbidity explore the effect of sex on help-seeking for mental disorder further. Most report that females are one and a half to two times more likely to help from a healthcare professional/GP than males. This applied to whole sample analyses^{37,127-129,134,135,137,143,144,149}, - for instance the UK national survey where the odds ratio of females seeking help compared to males was 1.8^{37,149} - and also amongst cases only¹²⁹⁻¹³² (Table 3.7). Odds ratios for help-seeking amongst females cases compared to male cases range from 1.6¹²⁹ to 2.0¹³¹. This relationship is also evident from prevalence estimates which suggest that between a third to two fifths of female cases seek help compared to just a fifth and a third of male cases^{37,130,131}.

Table 3.7: The association of sex with help-seeking amongst cases

Study	Cases seeking-help (%)		Odds ratio (females compared to males) and help-seeking	
	Male	Female	OR (95%CI)	p
Meltzer et al '95 ³⁷ (National Psychiatric morbidity study, UK)*	27	40	-	-
Andrews et al '01b ¹²⁹ (ASMHWB, Australia)	-	-	1.6 (not reported)	-
Issakidis & Andrews '02 ¹³⁰ (ASMHWB, Australia)(Anxiety only)	32	40	not reported	0.06
Bland et al '97 ¹³¹ (Canada)	21	35	2.0 (1.4-3.1)	<0.001
Galbaud du Fort et al '99 ¹³² (Canada) (Depression only)	-	-	1.9 (1.5-2.5)	<0.001

* Help-seeking from a GP past year

One paper explored the possibility that type of disorder mediates this sex difference on the basis that there is a female preponderance of mood and anxiety disorders, which are associated with greater service use. While this explained some of the relationship, females still sought more help than males¹³⁴. One paper presenting the findings of whole sample analysis¹³⁵ also reports data for help-seeking from informal help-sources (excluding friends and family). Females were twice as likely to seek such help (OR 2.1, 95%CI 1.6 to 2.7) which was higher than their odds of seeking help from a GP or any healthcare professional (OR 1.6) in the same survey. Five papers report no sex differences in help-seeking^{133,138-141} but three of these are small-scale studies¹³⁸⁻¹⁴⁰ and one¹³⁸ was based only on respondents recognising their disorder which some suggest may be a dimension of sex difference in help-seeking (below).

The relationship between gender and help-seeking is explored in more detail by papers considering the *nature* of help-seeking differences between males and females. One paper cites evidence suggesting that gender differences are explained by females' increased tendency to recognise problems and symptoms as those of mental disorder¹⁵⁰. In this paper, there were no further gender differences in perception of need for help or actual help-seeking once disorder had been recognised, however, later papers have found that females are also more likely to perceive need for help (below). Several papers also report that the increased rate of female help-seeking evidenced in the primary care setting was not replicated in secondary or specialist settings^{136,151,152}. Here overall service

use was similar, but males had more emergency contacts and emergency and involuntary admissions¹⁵². A possible interpretation is that females obtain help at an earlier stage before the seriousness of their condition provokes social/medical response¹⁵⁰. This is supported by an early sociological study¹⁶⁹ and a general practice-based study of psychosocial consultations which found that compared to males, females were more likely to self-refer, present with less chronicity, and with symptoms that did not result in formal diagnosis¹⁷⁰, though it is possible that the latter may also be influenced by gender bias in the diagnostic practice of some GPs.

Other sociodemographic factors

The associations of other sociodemographic factors with help-seeking are explored in cases only and whole sample analyses revealing a general coherence across studies.

Amongst cases:

- Non-white respondents sought less help than those who were white¹⁴¹.
- Living in an urban compared to rural location did not affect help-seeking^{130,133,140} – however, findings from specific populations indicate that rurality can prohibit help-seeking due to increased risk of stigma¹⁷¹
- Unmarried respondents, in particular, the divorced, separated and widowed were more likely to seek help than those who were married^{129-131,138,141}.
- Educational level^{130,131,133,138-141} and income^{131,133,138-141} show no association.
- The unemployed or economically inactive were the most likely while those employed full-time were the least likely^{131,141} to seek help.

There were some exceptions to these findings. A Canadian paper^{133,134} reported no association with marital status and Australian data show no association between occupational status and help-seeking¹²⁷⁻¹³⁰. Whole sample findings are consistent with patterns for cases^{37,127,128,134,135,137,143,144,149}, though two papers report that individuals from rural areas were less likely to seek help^{128,135} and some that a higher level of education was associated with help-seeking^{127,137,144}. UK data found no association between social class and help-seeking¹⁴⁹. Papers do not discuss whether these effects differ by age but, of potential relevance to young adults, Netherlands data¹³⁵ reveal those living with parents were less likely to seek help than those living in other household structures and

that students sought less help than other occupational groups, but these findings derive from whole sample analyses so their interpretation is limited.

Morbidity factors

A range of morbidity characteristics are also investigated as potential determinants of help-seeking behaviour. These tap into levels of severity and are used as additional 'measures of need' in order to explore whether some levels or types of need are more likely to provoke help-seeking than others. This analysis therefore moves beyond the simplistic division of respondents into cases and non-cases as in prevalence estimates by beginning to explore the continuum of experience disguised by such a dichotomy. All papers focus on seeking any healthcare or help from a GP.

The presence of symptoms and disorder

The association of psychiatric morbidity with seeking healthcare is explored at three progressive levels - having: 1) probable mental disorder (measured by GHQ score)¹²⁷, 2) symptom levels around the threshold for disorder (subthreshold symptoms)^{129,130,141,149}; 3) disorder (as measured by formal criteria)^{37,127,129,130,134,135,141,142,144,149}. The reported likelihood of seeking help increases with each level amongst those with morbidity compared to those without. Respondents with subthreshold symptoms of disorder were approximately three times more likely than those without symptoms to seek help for mental health concerns^{129,149}, while those with a disorder were between 4(OR 4.3¹³⁵) and 8 (OR: 8.3¹³⁴) times more likely to seek some form of healthcare and approximately 4 times more likely to seek help from a GP than those without disorder^{37,135,142}. Papers comparing the help-seeking of subthreshold 'cases' with those meeting criteria for disorder confirm the increased help-seeking associated with disorder^{129,130,141,149}. Confirming the pattern evident in prevalence estimates, papers note that odds ratios for help-seeking vary by diagnoses^{127-130,134,135,137,142} being highest for depression and affective disorder (5.2¹²⁷ – 8.3¹²⁸) and lowest for substance abuse (1.9¹²⁷ – 3.2¹³⁴).

Number and duration of symptoms

The number and duration of symptoms present are also examined as indicators of severity of psychiatric morbidity and a consistent pattern emerges in which the frequency of help-seeking increases with increasing number of symptoms. This is true at levels of symptomology below the threshold for caseness¹⁴⁹ and also amongst cases with disorder^{132,138,140,141,149}. The pattern is shown most clearly by the 1993 UK National

Psychiatric Morbidity survey data¹⁴⁹ which distinguishes four categories of symptom score based on CIS-R score - two below and two above the threshold for disorder (a score of 12). Help-seeking showed a stepwise association with CIS-R score (Table 3.8). This score represents the frequency and strength of symptoms as well as the number reinforcing the suggestion that the severity of disorder is associated with a greater likelihood of help-seeking, but still less than 60% of respondents with a CIS-R score in the highest category sought help.

Table 3.8: The association of help-seeking with number and strength of symptoms¹⁴⁹

Symptom score	OR (95%CI)
0-5 (non-case)	Reference category
6-11 (non and sub-threshold cases)	2.9 (2.4 – 3.5)
12 –17 (cases)	4.3 (3.3 – 5.5)
≥ 18 (cases)	7.8 (6.0 – 10.2)

Amongst cases, recurrent rather than single episodes¹³³ and episodes of longer duration^{132,133} are also reported to be positively associated with help-seeking.

Type of symptom

The influence of specific symptoms on help-seeking have been investigated by a small number of papers that compare help-seeking and non-help-seeking cases with a diagnosis of depression^{132,133,138,140,163}. Three report an association between suicidal thoughts and help-seeking^{132,133,138} but this attenuated where tested in multivariable analysis¹³³. Loss of weight or appetite was also more prevalent amongst help-seekers^{132,138,140}. It is speculated that this is because weight loss is interpreted as ‘physical’, or is noticed by others thereby provoking consulting, or that it may in fact be representing a relationship between chronicity and help-seeking¹³⁸. Findings relating to other symptoms such as cognitive impairment are conflicting^{132,138}. The general lack of association between depressive symptoms and help-seeking provokes the suggestion that low rates of help-seeking can be attributed to poor lay understanding of mental disorder and that this should be tackled by public health education¹³².

Psychiatric and physical comorbidity and disability

Comorbidity and disability are measured in order to distinguish levels of need and clinical status amongst those with disorder. Presence of either is taken to indicate ‘high

need³⁴. A positive association with help-seeking for mental disorder is reported for both. Psychiatric comorbidity is measured according to the number of disorders experienced during the study period^{31,34,129-131,135,145} and in two studies^{132,133} by the presence of specific additional diagnoses. Data consistently show a steady increase in the likelihood of help-seeking as the number of disorders experienced increases. The only exceptional finding was that depressed cases with comorbid drug misuse were less likely to seek help (OR 0.6, 95%CI 0.4to1.0, p=0.03)¹³² which could suggest drug use is a coping strategy adopted as an alternative to help-seeking and is of interest since comorbid drug misuse is most common amongst mentally disordered young adults³¹. Physical comorbidity is associated with mental health help-seeking in cases only^{127,129,133,138} and whole sample analyses^{37,127,137,149}.

The association of disability with mental health help-seeking is discussed in five papers based on the ASMHWB survey^{34,127-130} and two others^{133,149}, but only three Australian papers ^{34,129,130} and one Canada¹³³ paper focus on cases only. The Australian papers suggest that significant mental health-related disability is associated with increased help-seeking reinforcing the link between severity and help-seeking. This finding is not replicated in the Canada paper but this study did not distinguish between mental and physical health-related disability making its interpretation ambiguous.

Summary

- Understanding of the factors associated with help-seeking is limited as many papers, including those describing data from the UK national psychiatric morbidity study, take a ‘whole sample’ approach, while ‘cases only’ analyses are often limited by sample size reducing their potential to detect important associations. Factors that appear to show some association with help-seeking are summarised cautiously in Table 3.9.

Table 3.9: Factors showing association with help-seeking in cases with disorder

Socio-demographic
Middle adulthood
Female
White
Divorced, separated or widowed
Unemployed or economically inactive
Morbidity
Number, frequency and severity of symptoms
Recurrent/ chronic episodes
Psychiatric and physical comorbidity
Mental health-related disability

- Young adults emerge as the lowest consulters alongside older adults. Those aged 25-54 years were 1.5 – 2 times more likely to seek help than young adults.
- Males are also low consulters. Females are approximately two times more likely to seek help than males.
- Morbidity factors show the strongest associations, but while ‘clinical need’ is associated with increased help-seeking, researchers observe that a considerable proportion of those with ‘high need’ do not seek help.
- Papers do not look at the possible differential effects of factors according to age or suggest reasons why young people may be less likely to seek help than other age groups.

Illness behaviour

Some general population surveys also attempt to explore aspects of illness behaviour as a means of providing some understanding of the patterns of service use observed. They do this by examining barriers to help-seeking and respondents’ perceptions of their need for help. Some explicitly acknowledge the theoretical contributions of sociology (Chapter 2) and use this to frame their approach¹⁵³.

Help-seeking barriers and triggers

Some general population surveys quantify barriers to help-seeking and other reasons for not seeking help reported by cases^{130,133,137,154-157}. UK data are provided by Meltzer et al (2000) based on 1993 National Psychiatric Morbidity survey data¹⁵⁶. These are supplemented by a USA survey of an unrepresentative, well-educated sample mainly composed of women¹⁵⁸. All papers focus on help-seeking from any healthcare source, or a GP.

The papers collect data from differing subgroups of respondents. Three compare the barriers reported by help-seekers versus non-help-seekers^{133,137,154}, one considers non-help-seekers only¹⁵⁸, and five, including the UK survey, consider a subset of respondents that report episodes of distress for which they did not consult despite perceiving a need for help^{130,147,155-157}. Meltzer et al¹⁵⁶ describe these as ‘reluctant’ help-seekers who acknowledge specific instances of non-help-seeking and therefore provide a means of directly exploring barriers. This approach allows the inclusion of respondents who had sought help for other episodes^{155,156,158}. The studies also use different approaches to data

collection. Some, including the UK survey, asked respondents to volunteer barriers/ reasons for non-help-seeking^{154,156,157} while others asked respondents to endorse items from a pre-prepared list, some enquiring about only a minimal number of issues^{130,133,137,147,158}.

Despite these differences, consistent themes emerge across studies (Table 3.10), though the frequency with which these were reported vary according to whether respondents were asked to volunteer or endorse reasons, the former producing notably smaller proportions for each barrier. The scale of this difference is demonstrated by one paper which records results from each approach¹⁵⁵.

Table 3.10: Barriers to help-seeking reported in general population surveys

Barrier	Respondents reporting*		UK data ¹⁵⁶
	Volunteered	Endorsed	Volunteered
<i>Practical</i>			
Financial cost	6% - 16%	10% - 47%	-
Time/ opportunity to consult	1% - 6%	7% - 22%	6%
Physical access – eg. transport	1% - 5%	2% - 9%	-
<i>Perceptions of need</i>			
Did not recognise as illness	34%	-	-
Thought problem not bad enough for ‘help’	4% - 17%	43% - 54%	17%
Thought problem would ‘get better by itself’	6% - 15%	65% - 72%	15%
Thought I could ‘handle the problem alone’	-	35% - 77%	-
Thought I <i>should</i> cope alone	10% - 23%	80% - 83%	23%
Preferred to cope alone	-	58%	-
<i>Fears</i>			
Embarrassed to discuss personal issues	6% - 13%	6% - 38%	13%
Of negative social responses	2% - 4%	13% - 63%	4%
Of treatment	2% - 10%	9% - 24%	10%
<i>Knowledge and beliefs about help</i>			
Did not know where to obtain help	3%	16% - 26%	3%
Believed treatment would not help	3% - 28%	6% - 46%	28%

*Shows range across studies reporting each barrier
Sources: 130,133,137,154-158

Practical barriers appear to be of relatively minor importance^{130,137,147,154-158}, particularly to respondents in the UK survey¹⁵⁶. The most frequently cited reasons for non-help-seeking were issues relating to the perception of need^{130,147,155,156,158}. In two studies, these data can be viewed directly alongside external measures of morbidity relating to the same episodes revealing evidence of a significant need^{147,158}. Reasons offered such as ‘a belief that I *should* be able to cope alone’ suggest that social values may be a barrier to acceptance of need and help-seeking. Three fears also emerge as barriers to help-seeking: concerns about social attitudes and disapproval^{130,133,156,158 155}; embarrassment^{133,147,155-158}; and fear of what treatment might entail such as drug side-effects¹⁵⁶; hospitalisation^{155,156};

and having a record of treatment¹⁵⁸. A belief that treatment would not help was the most common reason (28%) for not consulting in the UK survey¹⁵⁶.

Differences between help-seekers and non-help-seekers

Three studies attempted to explore differences in the barriers reported by help-seekers compared to non-help-seekers^{133,137,154}. They found that help-seekers, unsurprisingly reported significantly less or no practical barriers^{137,154}, were more likely to report 'feeling comfortable' seeking help¹³³, and less likely to think they would be embarrassed to tell friends or family if they sought help from health services¹³³.

Socio-demographic correlates

The UK survey also provides data about the socio-demographic factors associated with the reporting of specific barriers¹⁵⁶. Younger people (aged 16-34 years) were almost twice as likely than those aged 35 years or above to think that consulting a GP was not necessary during episodes of mental distress (OR 1.88, 95%CI 1.05-3.37)¹⁵⁶. Those aged between 16 and 34 years were also more than twice as likely to report being 'too embarrassed to discuss' mental health problems as those aged 35 years or above (OR 2.4, 95%CI 1.2-4.8). The same was true for men compared to women (OR 2.4, 95%CI 1.2-4.7).

Help-seeking triggers

In one study¹⁵⁸ help-seekers were presented with a list of possible help-seeking triggers. Those endorsed most frequently were: feeling the distress was 'too bothersome'; thinking the episode had lasted too long; disruption of interpersonal and role functioning; and a perception that symptoms were getting worse. The authors interpret these as factors that distinguish help-seekers and non-help-seekers and can explain help-seeking, but in fact, the study creates an artificial distinction between help-seekers and non-help-seekers by asking one group to endorse triggers and the other barriers, when 'triggers' such as bothersome symptoms and disruption of functioning may apply also to non-help-seekers yet not provoke help-seeking and, similarly, help-seekers may also encounter barriers.

Limitations

Although these data begin to explore the reasons for non-help-seeking their interpretation is limited:

- Studies are based on specific subgroups only and so are not inclusive or representative investigations of barriers to help-seeking. For instance, some studies of 'reluctant help-seekers' (above) are based on as few as 9%¹⁵⁵ - 25%¹⁵⁶ of all cases and contain a higher proportion of respondents who have sought help on other recent occasions than those who have sought no help at all ¹⁵⁶.
- The endorsement approach of most studies limits understanding to pre-defined issues of importance and could encourage post-hoc rationalising of behaviour.
- Most studies are based on only those respondents who perceived a need for help so cannot investigate lay diagnosis as a barrier to help-seeking.
- Complex beliefs and perceptions, for instance, about the need for help, are quantified without exploration of the factors or context underlying these.
- Studies comparing help-seekers and non-help-seekers cannot ascertain if differences in attitude or belief were formed pre or post help-seeking.

Perceptions of disorder and the need for help

Of the barriers identified, respondents' perceptions of the 'need' for help, are explored further by some surveys^{129,130,133,137,147,153,155,157,159-161}.

Perceptions of mental health

The relationship between respondents' perceptions of their mental health and help-seeking is measured in two surveys – Lin et al 1999¹³³ (Canada), and Leaf et al 1985¹³⁷ (USA). Lin et al asked cases with DSM-III-R depression to judge whether they had 'mental problems' in the past year. Over two thirds of those who had sought help, compared to less than half who had not, perceived themselves to have a problem. This was one of the most consistent differences found between help-seeking and non-help-seeking cases in this survey. Leaf et al report similar findings. When controlling for disorder, those perceiving their mental health to be less than good on a four point Likert scale were three and a half times more likely to seek mental health care (OR 3.59, 95%CI 2.12-6.08). This was the strongest indicator of help-seeking after existence of disorder.

Perceived need for help

Mostly, papers report the prevalence of 'perceived need' amongst the whole study sample^{147,157,159,161} but these findings are difficult to disentangle from actual risk factors

and patterning of disorder. Data about perceived need amongst cases are more informative, quantifying the extent to which those with a formally identified ‘need’ for help recognise this need^{130,147,153,159-161}. The reported prevalence of perceived need (past year) amongst cases varies between 32%¹⁵³ and 61%¹⁶⁰ in surveys of all adults, and was 48% in a survey of women¹⁴⁷. The higher estimate is based on data from an extended questionnaire to assess perceived need which included ‘need for information’ as well as treatment¹⁶⁰, while the others used a single question, and asked about treatment only.

The factors associated with perceived need for help amongst cases (controlling for psychiatric morbidity) are entirely consistent with those associated with actual patterns of use (above) and are summarised in Table 3.11

Table 3.11: Factors associated with perceived need amongst cases with disorder

Sociodemographic <ul style="list-style-type: none"> • In middle adulthood^{129,153,160} • Female(OR 1.8, 95%CI 1.2-2.8)¹⁵³ • Divorced, widowed or separated¹⁵³
Morbidity <ul style="list-style-type: none"> • Mood/ affective disorders^{160 129,153}. • Co-morbidity (OR 1.9¹⁶⁰ & 2.0-6.4 (depending on diagnoses)¹⁵³) • Disability (OR 2.9^{153,160}) • Suicidal thoughts/ behaviour in the past year (OR4.1)¹⁵³
Additional <ul style="list-style-type: none"> • Having a positive attitude towards mental health help-seeking¹⁵³ • Having parents who had experienced mental disorder¹⁵³

Young adults with disorder were approximately half as likely to perceive a need for help as those in the middle years of adulthood (18-24yrs : OR 0.45, 95%CI 0.31-0.65, ref. group 25-44yrs¹⁶⁰, 15-24yrs: OR 0.5, 95%CI 0.3-0.8, ref. group 25-54yrs¹⁵³). Young adults were also the age group least likely to perceive a need for medication (OR 0.40, 95%CI 0.26-0.62, ref. group 25-44 years)¹⁶⁰.

The association of ‘perceived need’ and help-seeking

The consistency between the factors associated with perceived need and those associated with actual service use suggest an association between perceived need and help-seeking. This is reinforced by the Australian National survey as most non-help-seeking cases including those with comorbid diagnoses or disability, perceived no need for help^{129,130,159}. In contrast, there was a high perception of need amongst those cases who did seek help in the same survey - 94.5% of help-seekers ¹⁵⁹. The proportion of service use in those with and without perceived need is also compared in one USA paper

revealing a strong relationship between the perception of need and whether or not help was sought, but, help-seekers were assumed to have perceived need unless their treatment had been enforced which may have exaggerated this finding¹⁶¹.

Studies report that between 40% and 60% of those with perceived need actually obtain help^{147,153,157}. Cases perceiving a need for help were more likely to seek help if they were older (35-55 years¹⁵⁷, 45-54 years¹⁵³), female¹⁵⁷, had physical morbidity, and a positive attitude to mental health help-seeking¹⁵³. Other papers quantify the proportion of respondents reporting an episode where they had not sought help despite they, family or friends thinking they needed to. This ranges between 9.4% and 25% of cases^{135,147,155,156}.

Interpretation of these data is difficult. The perceptions of those who have sought help may be shaped by being diagnosed and treated and are not necessarily reflective of perceptions when seeking help. Similar difficulties occur in relation to data regarding perceptions of mental health status and help-seeking. The relationship may also be confused if those unwilling to seek help are also unwilling to self-report 'need'.

Limitations of general population surveys

General population surveys are based on large, representative community samples and are able to access hidden morbidity. They are useful in quantifying the scope and dimensions of the problem of non-help-seeking and identify some broad patterns. However, they also suffer from limitations. They:

- Often rely on screening tools in place of psychiatric assessments to make diagnosis.
- Are vulnerable to recall bias as mostly they ask about symptoms and service use over the past year. Recall could be affected by the illness behaviour adopted. This problem is reduced in the UK national surveys which focus on current symptoms.
- Cannot explain why certain factors are associated with help-seeking or account for the temporal sequence of relationships between variables such as perceived need and help-seeking and therefore have limited explanatory power.
- Do not always match estimates of help-seeking to disorder - some studies collect help-seeking data over the last year but match this to current symptoms or symptoms experienced over a shorter time frame. Where considering specific disorders it is not known whether consultations can be attributed at all, or singularly to the diagnosis of interest.

- Exhibit large variations in study design that hinder comparison of data across studies (Table 3.12). On occasion, variation also occurs across multiple publications reporting on the same survey.
- The cross-sectional and quantitative design means help-seeking is reduced to a binary outcome and so cannot be investigated as a process. It is treated as a single act overlooking the complexities that lie behind this. Further, surveys provide a population level estimate of the prevalence of service use at a point in time but cannot quantify the likelihood of individual cases seeking help at some point in their illness trajectories, and the use of lay sources of help is scarcely considered, despite the clear importance attached to this by illness behaviour theory (Chapter 2). In short, general population surveys measure service use - not help-seeking.

Table 3.12 Main variations in study design across general population surveys

<p><i>Inclusion criteria</i></p> <ul style="list-style-type: none"> • The ages included and their categorisation in analysis. The lower age limit ranges from 15 - 22 or more years, and the upper limit from 54 – 64 years. • Disorders included within the category ‘mental disorder’. Variation particularly exists in the inclusion or exclusion of addictive and psychotic disorder and anti-social behaviour. Studies considering differential rates of service use according to disorder indicate these differences could have an impact on observed help-seeking patterns. <p><i>Means of assessing disorder</i></p> <ul style="list-style-type: none"> • Definitions and criteria for disorder, for example, ICD-10 versus DSM. This is further complicated as the period over which studies have been conducted has encompassed three differing versions of DSM (III, III-R, IV). • The time period over which disorder is measured. • The use of differing screening measures, diagnostic tools and case thresholds to define ‘cases’ with disorder and inclusion of sub-threshold cases in some studies. <p><i>Measurement of help-seeking</i></p> <ul style="list-style-type: none"> • The definition of help-seeking, varying from ever ‘telling someone about a problem’ and not distinguishing if this was done indirectly or as the purpose of the consultation and with a view to receiving treatment, to purposefully seeking help for a mental or emotional problem. • The time period over which help-seeking is measured. • The help sources that are considered and the categorisation of these into ‘types’ of help. In particular, studies vary according to whether they distinguish social care and healthcare.
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Surveys of illness behaviour

A much smaller body of literature is concerned solely with illness behaviour – mainly in relation to depression. This includes 1) surveys of ‘anti-depressive behaviours’ recommended by the general public, and 2) vignette surveys exploring lay diagnosis,

perceptions of need and help-seeking options with general population samples. Both are based on hypothetical scenarios and do not measure morbidity.

Surveys of 'anti-depressive' behaviours

Surveys of 'anti-depressive' behaviours¹⁷²⁻¹⁷⁷ are dated, mainly UK-based, and with just one exception¹⁷⁶, based on small (n=50-100), convenience samples of university psychology students and staff, general practice attenders or hospital outpatients. Respondents were asked to volunteer^{172,175} or endorse from pre-defined lists^{173,174,176,176,177} the coping strategies and help-seeking options they recommended for feelings of depression¹⁷²⁻¹⁷⁵, when 'going through personal difficulties, emotional problems or trouble'¹⁷⁶, or when facing the 'potentially depressing' scenarios of a relationship breakdown or significant criticism¹⁷⁷.

An extensive and diverse list of behaviours were volunteered or endorsed - several by each respondent. The most popular were: 'keeping busy'¹⁷³⁻¹⁷⁵, 'watching T.V.'^{173,176}, 'trying to solve the problem'^{172,175,176} and 'talking' about 'one's feelings'^{173,175,177}. Formal help-seeking was not a popular strategy, indeed respondents were equally or more likely to suggest avoiding healthcare professionals than seeking their help^{175,177} and taking anti-depressants was one of the least frequently endorsed or volunteered responses^{172,175-177}. Differences in preferred response to depression were identified according to social class^{176,177}, personality¹⁷³, age^{176,177} and sex¹⁷⁵⁻¹⁷⁷. Younger respondents (age not specified) were more likely to endorse socialising and reckless behaviours¹⁷⁷ and to 'watch T.V.', drink, smoke, and exercise, while older respondents were more likely to endorse consulting a doctor¹⁷⁶. Females volunteered more strategies^{175 177} and were less likely to endorse reckless coping or alcohol consumption, but more likely to seek help, 'keep busy' and engage in self-consoling activities^{176,177}. These data are supplemented by an unpublished survey where willingness to see a GP for 'stress and strain' increased with age, those aged 16-24 years being the least likely to endorse this²⁹.

These data are interpreted as indicating the presence of culturally learnt and approved repertoires for responding to feelings of depression^{172,174,175} and it is noted that formal help-seeking is not prominent. However, the studies are limited by their sampling (only one is based on a large cross-sectional sample¹⁷⁶) and use of pre-defined checklists of options, where help-seeking may be reduced to a singular item, eg. 'go to the doctor for pills'¹⁷⁶. Also, as they were conducted in the 1970's and 1980's, the data may not

represent current cultural attitudes, and their hypothetical design places limitations upon the extent to which correspondence with actual behaviour can be assumed. Further, without clear definitions of depression, these data are based on respondents' own and undefined concepts of 'depression' which could range from everyday distress to the clinical. Many subjects may never have experienced depression. It is therefore unclear to what situations or 'feelings' reported 'repertoires of antidepressive behaviour' would refer, for how long they might be adopted, and whether they are alternatives to help-seeking or initial responses that may later give way to help-seeking.

Vignette studies

The early studies described above have been superseded by vignette studies. These are based on large cross-sectional samples and, although still hypothetical, define the nature of the depression under consideration by presenting respondents with a scenario describing psychiatric disorder (for example, see Table 3.13). The parameters of the study are therefore held constant across respondents. These studies focus on help-seeking rather than self-care and are sociological in orientation, investigating issues such as lay diagnosis, as well as help-seeking sources. Ten papers¹⁷⁸⁻¹⁸⁷ and a review¹⁸⁸ were identified but these relate to a smaller number of surveys (n=6) conducted in Switzerland, Germany, America and Australia. One paper presents separate data for young adults (15-24 years) comparing this with data for older adults aged 65-74 years¹⁷⁸.

Table 3.13: Example of a depression vignette from Jorm et al 1997¹⁸⁷

John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John's lowered productivity.

Sources of help and treatment

Studies investigated the sources of help and treatment recommended for depression in three differing ways: 1) by presenting respondents with a list of potential help sources and treatments and asking them to judge whether each might be helpful or harmful to the vignette character^{178,180,182,184,187}; 2) by asking respondents to suggest help-sources^{178,187}; and, 3) by asking respondents to state help seeking preferences by identifying which help source they would consult first and then second^{179,184}. Some

consistent findings were obtained across studies, but important differences emerged according to which of these approaches was used (Table 3.14).

Table 3.14 Help-sources endorsed, suggested, and preferred in vignette surveys of depression

Help sources	Endorsed	Suggested	Preferred
Counsellor	74% - 92%	23%	-
Friends and/ or family	87%	20%	-
Friend(s) only	73% - 88%	-	35% - 42%
Family only	70% - 84%	-	12%
GP	58% - 83%	44% - 49%	26% - 30%
Telephone line (not specified)	30% - 69%	-	-
Anti-depressants	25% - 64%	3%	-

Sources:¹⁷⁸⁻¹⁸⁷

Most respondents were willing to endorse a range of medical and lay sources, especially a counsellor, friends and family. Their ranking was the same across studies (see Table) though the actual proportions endorsing each varied, which may be due to differences in the location of the study, the vignette used, or the method of data collection (postal questionnaires v. interviewing). Also, the study reporting the highest proportions of respondents endorsing the various help-sources (Jorm 2000 b & c) reports a low response rate (39%) and possible response bias – males and those aged 20-34 years being under-represented in the sample^{181,182}. The ranking of help-options deemed harmful was also consistent, though, with the exception of pharmacological treatments, no source was rated as harmful by more than 10% of respondents. Anti-depressants were rejected as harmful by between 34%¹⁸⁰ – 42%¹⁸⁷ of respondents which was a higher proportion than that perceiving them as helpful.

Studies asking respondents to suggest rather than endorse help sources illustrate that while a large number of respondents may acknowledge the helpfulness of a range of sources when confronted with closed questionnaire items, the frequency with which they suggest these is somewhat less. Although a GP was most frequently suggested as the source that could ‘best help’ the vignette character and friends and family the third most frequently suggested (Table), the picture differs further in the two studies^{179,184} tapping into help-seeking preferences by asking respondents to rank sources according to which should be consulted first and then second. Most respondents showed a preference for friends as the primary help source with resort to a GP second. A GP is the preferred source for just under a third of respondents, which is in keeping with general population data about actual service use by those with mental disorder. Family

members were a less popular choice. By introducing choice, these studies approximate more closely to actual help-seeking behaviour and decision-making.

One study^{182,183} attempted to assess the correspondence between these responses and actual behaviour by following up symptomatic survey respondents after six months and comparing their baseline vignette responses and subsequent actual illness behaviour. The study identified a large discrepancy between the endorsement of help sources and actual service use. For example, seeing a GP was endorsed by 81% of respondents but only actually consulted by 35%, while strategies that did not involve seeking help, such as drinking and taking vitamins were actually used more frequently than they had been endorsed. However, subjects were selected for follow-up on the basis of GHQ score at baseline, and as this is sensitive to misclassifying transient disturbances, this questions the extent to which all those followed-up had experiences comparable to the vignette scenario of DSM major depression and therefore the validity of the comparison made between belief and behaviour.

Age and gender

Compared to older adults, those aged 15 – 24 years were more likely to endorse a counsellor ($p < 0.001$) and lay sources ($p < 0.05$) as helpful but less likely to endorse a GP or tranquillisers ($p < 0.001$)¹⁷⁸. These findings were supported in studies of all adults in which younger age (not defined) was also associated with more positive beliefs about psychological interventions such as psychotherapy and counselling^{181,184,186,188}. In two surveys, females were more positive than male respondents about psychological treatments, confiding in the lay group, counselling, and lifestyle interventions such as exercise, but less positive about medical interventions^{181,186}, but another survey reported no gender difference¹⁸⁴. Findings therefore showed some consistency with those obtained in surveys of anti-depressive behaviour (above).

Lay diagnosis and perceptions of need

Vignette surveys have also been used to explore perceptual factors defined by sociological theory (Chapter 2) as relevant to help-seeking^{178,180,184-188}. Results are difficult to compare due to the differing methods used across surveys - some asking respondents for their level of agreement or disagreement with possible diagnoses^{180,184,185} and others recording unprompted responses to open-ended questioning^{178,186-188}.

Just under three-quarters of respondents either endorsed or volunteered some form of mental health category to describe the depression vignettes presented^{178,185,187} but less (39%¹⁸⁷ and 51%¹⁷⁸) correctly volunteered a diagnosis of depression. A small number of respondents interpreted the vignette as depicting work related problems or physical morbidity^{178,187}. In a further study, respondents displayed diverging understandings, 56% recognising the vignette to signify illness while 44% perceived this as a 'life crisis'¹⁸⁰. Beliefs about diagnosis and cause (as in a survey of anti-depressive behaviour (above)¹⁷⁵) were important to help-seeking recommendations. Respondents with medical views of symptom causation and who identified the vignette as depicting depression or a form of psychiatric disorder were more likely to recommend professional healthcare and gave more positive ratings of psychological treatments^{184,186}, anti-depressants¹⁸⁰, and psychiatrists^{180,184}. Respondents who recognised the vignette as depression were more likely to suggest GP help in one study¹⁸⁴ but not in a second¹⁸⁰. Conversely, if the cause was related to social problems such as unemployment or family problems¹⁸⁴ or the vignette was defined as 'life crisis'¹⁸⁰ respondents favoured talking to a confidant¹⁸⁴ or non-medical interventions such as telephone counselling and 'fresh air'¹⁸⁰.

Perceptions of the vignette character's need for help were high. In one study 80% of respondents believed that help of some kind was needed¹⁷⁹. In another, 63% considered it would be harmful for the character to 'deal with the problem alone' and more than 50% predicted a poor prognosis in the event of no help¹⁸⁰. Full recovery was expected if help was received by over 80% of respondents in a further two studies^{187,188}.

Summary and limitations

These data suggest there is a high level of acknowledgement amongst the general public about the potential usefulness of seeking help, including medical help, for mental distress, though respondents were less positive about pharmacological treatments. They also suggest that help-seeking choices are influenced by whether symptoms are interpreted as medical or social. However, there are a number of limitations associated with vignette surveys that make it difficult to draw conclusions about illness behaviour.

The major limitation is their hypothetical and impersonal nature. They measure subjects' responses to a specific, fictional case and so correspondence between help-seeking recommendations and actual illness behaviour cannot be assumed. In fact, one study suggests the correspondence is poor^{182,183}. Asking respondents to offer help-seeking recommendations for an anonymous person rather than themselves may account for the

high endorsement of healthcare help-seeking which is in great contrast to anti-depressive behaviour surveys (above). The 'second person' approach also means that weighing up the costs and benefits of seeking help - a hypothesised aspect of help-seeking decision-making (Chapter 2) - is less likely to be applied by respondents to the scenario. These studies may instead measure the ability to give what are regarded as 'correct' answers. The two surveys enquiring about help-seeking preferences may approximate more closely actual illness behaviour.

These surveys are also limited in the extent to which they can investigate illness behaviour by their quantitative approach. They do not allow respondents to discuss context and meaning or what may influence behaviour in a real situation, so provide little explanation of the beliefs and understandings underlying help-seeking preferences.

Qualitative studies

Qualitative research papers form a much smaller component of the literature investigating help-seeking for mental disorder¹⁸⁹⁻¹⁹⁸. They are summarised in Table 3.15. To avoid duplication, multiple papers relating to the same study are described together. They mainly have a sociological grounding based upon the general themes of illness behaviour (Chapter 2). The papers are all recent (1997-2003) and, in contrast to survey data, are mainly UK based. Some focus on depression^{189,197,198}, two were set in rural areas^{191,192}, and one is unpublished¹⁹⁶. The research subjects are either:

- 1) community samples (community-based) - some of whom may have experienced depression - engaged in general discussion about mental distress and help-seeking^{191,192,194-196}
- 2) consulting patients (patient-based) speaking both generally as above and discussing their experiences of mental distress and perceptions of care including some discussion of their experiences of help-seeking^{189,190,192,193,197,198}. Help-seeking is the focus of just two of these papers^{189,190}

Patient status rather than diagnostic scales mainly define mental disorder in these studies. One paper describes attempts to recruit depressed respondents who had not received formal treatment via community leaders (eg. lay ministers) though whether this was achieved is not clarified¹⁸⁹. As with survey data, the main emphasis is on seeking healthcare rather than lay help.

Table 3.15: Qualitative studies of help-seeking for mental disorder

Study	Method	Population and setting	Sample size	Diagnosis and screening	Main findings
Cooper-Patrick et al, 1997 ¹⁸⁹	Focus groups	Primary care patients. Adults aged 18+ USA, urban	16 2 groups	Depression. Determined by patient status	Patients were uncomfortable asking for help from lay group because of need to appear 'strong' and because lay group had poor understanding of depression. Patients reported a stigma associated with having depression and also with getting treatment for it. They were concerned about: interpersonal skills of GP, possible side effects and addition associated with medication, and the effectiveness of counselling, and disliked talking about personal problems. Particular symptoms associated with depression such as lack of motivation and self-blame acted as barriers to help-seeking.
Pescosolido et al, 1998 ¹⁹⁰	Semi-structured interviews	Patients making first contact with local mental health services Adults aged 18-72 USA, urban	109	S.M.I (largest category - 49% = major depression. Identified by SCID and DSM-III-R criteria	Pathways into care were complex and characterised by elements of muddling through (neither resisting or seeking treatment), coercion and choice. 46% entered care through a decision where they played the sole or main part. Choice was often supported by social networks. 23% resisted treatment and been coerced into this – usually by lay member. A third muddled through vacillating about treatment or focussing on coping with symptoms.
Fuller et al, 2000 ¹⁹¹	Semi-structured interviews	Community informants 'knowledgeable' about mental health problems e.g. GP, clergy, service users. Australia, rural.	22	N/A – community sample	Community respondents attributed reluctance to seek help to individuals' reluctance to define their problems as mental illness because this is equated with 'insanity' in the community and associated with a high degree of stigma. The rural community was characterised by a culture of self-reliance and stoicism that discourages members from seeking outside help.
Williams & Healy, 2001 ¹⁹²	Semi-structured interviews	Users of community mental health services and non-case non-users. Adults age not reported UK, North Wales, rural	34	Minor mental disorders, e.g. depression and anxiety Determined by patient status	Respondents discouraged from disclosing their mental health problems to the lay group in case this created a burden. They also reported high levels of felt stigma and were concerned that disclosure would make them appear weak, unable to cope with life problems and unable to suppress emotions – thus compromising social values. They therefore avoided disclosure. Seeking help from formal sources also communicated low ability to cope. Disclosure was seen as legitimate where causes of distress were considered severe.
Kadam et al, 2001 ¹⁹³	Semi-structured interviews and focus groups	Cases from population survey of general practice patients. Adults aged 18-75 UK, urban	n=18 interviews n=9 2 focus groups	Depression and/or anxiety Identified by HAD	Interviewees were too consumed by coping with symptoms to seek treatment. They believed lay people are intolerant of mental distress. They were positive about counselling though this was often inaccessible. Many thought GPs were too busy to listen to problems and would prescribe medications, which they were critical about on the basis that medication only suppresses the problem.

Table 3.15: Qualitative studies of help-seeking for mental disorder (cont.)

Pill et al, 2001 ¹⁹⁴ Prior et al, 2003 ¹⁹⁵	Focus groups	Community-based sample from network of general practices. Adults aged 18-70 UK, urban and rural Wales.	127 20 groups	N/A – community sample	Respondents were unsure about whether symptoms of emotional distress were legitimate illness and therefore of the appropriateness of consulting a GP. Real health problems were seen as physical. They also doubted whether GPs can give sufficient time to patients with emotional problems and had a poor perception of their abilities to treat emotional disorder. Most had negative views of anti-depressants. Talking was seen as important and counselling was the preferred option. Stigma did not appear as a central theme.
Bellamy & Purvis, 2001 ¹⁹⁶ (Unpublished report)	Focus groups	Community-based panel members. Adults aged 18+ UK, urban and rural (Somerset)	96 number of groups not reported	N/A – community sample	Respondents thought stigma significantly affected individual's willingness to seek help, including the fear of being seen as weak and the desire to uphold 'English stoicism and reserve'. It was thought that people are less supportive of those suffering mental than physical illness. The lay group was seen as an important help source but GPs were thought to lack time for emotional complaints.
Rogers et al, 2001 ¹⁹⁷ Gask et al, 2003 ¹⁹⁸	Semi-structured interviews	Patients currently being treated by GP for depression Adults 20-69 UK, urban	27	Mild/ moderate depression treated in primary care and not necessitating specialist services. Determined by patient status	Pathways to care were varied. Patients experienced difficulties in verbalising their need for help and communicating with GPs. They may not seek help due to feelings of low self-worth, shame or reluctance to admit 'weakness'. Some did not perceive their problems as legitimate illness or 'medical' problems. A GP was often the most accessible help source but many respondents believed a GP could not help and lacked time to deal with depression. Patients were concerned about wasting the GPs time/ being a 'bad' patient. Some were concerned about being prescribed medication or referred to a psychiatrist associating this with loss of control and stigma.

Lay concepts and definition of mental disorder

Several papers describe lay understandings of mental disorder and how these relate to lay diagnosis. Respondents perceived stress and depression to be separate but related. They also identified different 'types' of depression including 'feeling down' versus 'the actual illness depression', post-natal and 'teenage' depression¹⁹⁶. Community samples and patients accounted for depression and other forms of mental distress in differing ways: as biological or an outcome of having physical illness^{189,196}; as self-inflicted¹⁹⁶; or caused by an inability to cope with everyday life and pressures^{196,197}. Most frequently, life events and problems such as unemployment and work stress were implicated as the cause^{189,191,196}. Accordingly, there was a tendency to conceive of mental health problems – mild and severe – as social problems or problems of everyday living rather than illness^{191,195} and it is suggested that this lack of recognition of distress as a mental health problem may mean that healthcare services are not perceived of as an appropriate help source¹⁹¹. These findings develop further those of vignette studies indicating a divergence between social and medical models for understanding depression and the possibility that this may influence illness behaviour.

In a community-based study, most respondents believed that those suffering from mental distress would be unable to recognise this until it had reached considerable severity on the basis that mental symptoms lack a physical and tangible presence and that their depressive symptoms would prevent them from seeing a purpose to help-seeking. Respondents thought friends or family would recognise signs of distress first and therefore encourage help-seeking¹⁹⁶.

However, in two studies – one community-based (Pill et al 2001¹⁹⁴, Prior et al, 2003¹⁹⁵) and one patient-based (Rogers et al 2001¹⁹⁷, Gask et al 2003¹⁹⁸) – issues of how to classify symptoms emerged as more important than recognition. Prior et al 2003 describe their respondents as 'unclear' about where to 'draw the line' between illness and normal 'problems of living'¹⁹⁵, and Rogers et al report episodes where respondents struggled to identify the nature of their disturbed behaviour and feelings, concluding that *'establishing the nature of the problem was an inherent difficulty in accounts of help-seeking'*¹⁹⁷. In both studies, problems of classification centred round debate about whether or not emotional/mental symptoms were legitimate forms of illness or trivial and 'normal problems'. Respondents contrasted emotional with physical complaints, which they held

to be examples of 'real' illness while emotional symptoms were not. It is concluded that emotional or mental distress did not belong to respondents' 'world of illness'¹⁹⁵. This meant that mental distress was seen as outside the scope of what was 'medically treatable' and so an inappropriate matter for which to consult a GP or other healthcare professional^{195,197}. Instead, respondents thought the problem should (or could only) be dealt with by the individual - even if it was perceived as serious^{194,195,197}. In one study, respondents expressed particular confusion about the appropriateness of consulting a GP about feeling suicidal because although they considered this to be serious, they also saw it as 'non-physical'¹⁹⁵. Prior et al conclude that these issues surrounding the classification were the most significant reason why respondents did not suggest seeking help from health professionals for mental distress¹⁹⁵.

The failure to classify mental disorder as illness may relate to a lack of recognition (above) or an unwillingness to acknowledge distress¹⁹⁴. The idea of unwillingness is discussed in a further study carried out in a rural setting¹⁹¹. Community respondents thought most people in their community associated 'mental health' with severe mental illness/insanity requiring institutionalisation and so do not talk about their own experiences of distress in terms of mental health. The authors interpret this as a reluctance to acknowledge mental health problems which they speculate translates to failure to seek appropriate help. Accounts of those with distress are not available to support this.

Pathways into care

Of those studies considering respondents who had sought help, two noted that respondents' pathways into care were variable, occurring at a range of points throughout the illness trajectory, often entailing delayed help-seeking, and the outcome of differing means and triggers^{190,197}. One study (Pescosolido et al, 1998¹⁹⁰) focuses specifically on this issue and identifies three differing pathways by which respondents (with major depression or other severe mental illness (S.M.I.)) had come into contact with formal help services - choice, coercion and 'muddling through'. Although choice was the most common pathway, still less than half the respondents had 'chosen' to enter health services themselves or because of lay advice. The smallest number of respondents had been coerced into care by the lay group or legal mechanisms. A third of the accounts were characterised by 'muddling through'. This involved improvising and attempting to deal with emerging problems while neither seeking nor resisting treatment until 'ending

up' being treated. Some of these respondents had not perceived a need for treatment. In these instances, treatment followed suicide attempts, and more usually, lay intervention as friends or family took control of the trajectory with neither agreement nor resistance from the individual. Although only a third finally entered the healthcare system by 'muddling through', Pescosolido et al note that most respondents' help-seeking trajectories entailed some component of 'muddling' and were rarely quick or non-problematic.

Pescosolido et al underline the significance of the social network to the pathway taken. They identify two types of narrative of lay referral in respondents' accounts - supported choice and coercion. In narratives of supported choice, friends and family encouraged help-seeking by drawing the individual's attention to their problems and confirming that these were worthy of help-seeking. In some cases, the lay group were more proactive, suggesting directly that help should be sought, or even instigating help-seeking with the individual's agreement. In narratives of coercion, members of the social network forced the individual into treatment despite resistance. Quantitative analysis found that those respondents with large and close social networks were more likely to describe narratives of coercion¹⁹⁰.

Importantly, the data presented in this paper are used to critique two key assumptions of the existing theoretical and empirical literature on service use/ help-seeking: 1) the assumption of traditional utilisation models that service use is the outcome of an individual's rational decision-making, 2) that 'use' is a homogeneous category that can be treated as a single outcome as in general population surveys.

Help-seeking barriers

Respondents described a range of barriers to help-seeking. These were derived from either: 1) real accounts of factors that had at some stage deterred patients from disclosing their distress; or 2) the hypothetical speculation of community samples. Some of the barriers described provide further clarification of those reported in general population surveys while others are new insights accessed by the qualitative approach.

Practical barriers

Practical barriers discussed share much similarity with those emerging in general population surveys with concerns about distance and travel to the location of care¹⁸⁹, time constraints¹⁸⁹, waiting times, inability to obtain a 'same day' appointment^{193,196} and,

in American studies, cost and insurance¹⁸⁹. A lack of knowledge and public awareness about where to find information and help in times of distress and the appropriateness of doing so was also cited as a barrier¹⁹⁶.

Opportunity and ability to communicate about mental distress

Patients in one study are portrayed as anxious about how they would raise and convey their emotional problems to their GP. They experienced difficulty in adequately communicating about depression and knowing how to address and explain symptoms. The researchers suggest patients lack both an adequate vocabulary and a sufficient conception of mental distress through which to understand and then communicate needs. This is contrasted to consulting with physical disorder which is well-rehearsed from prior experience^{197,198}. Communication of mental health problems was also inhibited by the fear of being labelled as a 'bad' patient¹⁹⁸ or as a nuisance¹⁹³.

Cognitive and symptom related

In some patients, particular symptoms and cognitive disturbances associated with their disorder such as self-blame, low self-worth and lack of motivation appeared to interfere with the act of seeking help and ability to perceive a need for, entitlement to and benefit from help^{189,198}. Communication with health professionals was also interrupted by anger, irritability, anxiety and an inability to express coherently concerns and needs¹⁹⁸. Similarly, one paper describes those interviewed as too consumed by the challenge of coping with, and searching for respite, from symptoms – usually by distraction – to proactively deal with these and search for solutions¹⁹³.

Fear of labelling and stigma

The fear of being stigmatised following disclosure of mental disorder and receipt of treatment is discussed as a significant barrier to seeking help from various sources by respondents in several papers^{189,191-196}. Respondents believed that people with mental disorders are accorded less social acceptance than those with physical disorders^{189,191,193,196}. This ranged from a lack of support and understanding evidenced by phrases such as 'pull yourself together' and attributed to non-visible symptoms^{193,196}, to the application of stigmatising labels such as 'nutter'¹⁹⁶ and the perception that those with disorder or in receipt of treatment are mad, 'weird' or dangerous^{189,191}. Such negative attitudes were attributed to family, friends and colleagues.

Williams & Healy, 2001¹⁹² reach the conclusion that individuals are 'as concerned' about the social consequences of their illness as they are about its clinical prognosis. However, Prior et al 2003¹⁹⁵ debate whether the degree of importance attached to stigma has been exaggerated or assumed by researchers rather than drawn from actual respondent accounts and a full investigation of the processes involved in help-seeking. In their community-based study, Prior et al¹⁹⁵ (see also Pill et al 2001¹⁹⁴), they found that stigma was only a 'peripheral' reason for non-disclosure and that issues of recognition and definition (above) were far more important to how people presented their distress than a deliberate attempt to conceal it. They argue that a disproportionate focus on stigma has limited examination of such issues of definition. The respondents in this study mentioned stigma infrequently, though the issues raised were similar including, belief that it may be undesirable to disclose distress in case this affected employment opportunities, and led to a 'record' of emotional instability.

Felt stigma and cultural values

In several studies, respondents described a number of further negative evaluations that they associated with being mentally distressed, and in particular with seeking help for this. Respondents implied these may result in individuals attempting to conceal their problems instead of seeking help^{192,193,196,197}. These were feeling or being seen as weak, a failure, as unable to cope especially with 'ordinary stresses of life', and having little self-control or ability to suppress emotions, and were particularly emphasised by male respondents in community¹⁹⁶ and patient samples^{192,197}. Such evaluations provoked felt stigma and feelings of shame and embarrassment which could make respondents unwilling to admit to the existence of their mental problems.

In some studies, such evaluations were related to specific cultural values and 'moral attributes'¹⁹² cited by respondents and regarded as incompatible with help-seeking. These consisted of a perceived 'English attitude' or the 'British stiff upper lip' which entailed being stoical, 'putting on a brave face', and suppressing rather than talking about distress^{192,196} and also the belief that feelings of stress and depression should be 'coped with' and managed by the individual or informally and without outside help¹⁹²⁻¹⁹⁶. In this context, counselling was seen as an American concept¹⁹⁶ and resort to medicine as an admission of failure¹⁹³. Where formal help was sought, the same values of stoicism limited the extent to which some patients discussed their symptoms and treatments in consultations and sought follow up appointments¹⁹⁸. A 'culture of self-

reliance' and stoicism is also described amongst rural Australians and similarly cited as a reason for not seeking help in case doing so is perceived as weakness¹⁹¹.

In two studies^{192,195}, respondents specified contextual factors that they thought modify the extent to which stigma and other negative evaluations are likely to be associated with mental distress and help-seeking. Disclosure of distress was permissible in response to identifiable events such as bereavement that are considered of sufficient severity and duration to justify the person being unable to cope.

Perceptions of help-sources

Most qualitative studies include data regarding respondents' views about potential sources of help for mental distress^{189,192-198}. No real differences emerge between community-based and patient samples, except an acceptance of the GP as a main source of help by patients but not community samples though as with cross-sectional surveys it is not possible to tell whether this reflects their experiences with primary care or a prior difference in belief. Coping behaviours also featured in several studies as an appropriate response to distress – particularly as a preliminary response before seeking formal help – though sometimes coping entailed denial or negative behaviours¹⁸⁹. Patients in one study were described as 'actively' seeking alternative therapies including acupuncture, reflexology, self-help books and groups¹⁹³.

General Practitioner

The GP was regarded as a main or primary source of help by disordered cases in one study¹⁹³ and consulted by patients in another mainly because they appeared to be the most or only accessible help source and more acceptable than alternatives such as secondary care (below)¹⁹⁷. However, in these and other studies^{189,194,196} many respondents: 1) queried whether it was appropriate to bring emotional problems to primary care and, 2) had low expectations about the extent to which a GP could actually help. They therefore described several reservations about consulting.

While some respondents believed that GPs are willing to listen and appropriately refer, several others argued that they do not encourage patients to disclose emotional problems and symptoms¹⁹³ and may not be tolerant of such presentations¹⁹⁴. Doctors were seen by many respondents across studies to lack sufficient time to listen and deal adequately with emotional symptoms^{193,194,196-198}. This was believed to limit patients' opportunities to discuss important issues and, consequently, GPs' understanding of

their problems^{193,196}. In one community-based study, doctors were perceived to be interested only in physical disorders, since it was such disorder that was regarded as 'real' illness (above)¹⁹⁵, and the quotations presented here and by Rogers et al 2001¹⁹⁷ portray a sense that it is "easier" to get a GP's help for physical symptoms because there is something obvious to present¹⁹⁵. Respondents in several studies questioned the legitimacy of consulting with mental distress on the basis that it is 'non-medical' and so not something a doctor could help with^{195,197} and also believing that emotional problems are trivial in comparison to physical illness. In such a context, they feared that to seek help would 'waste a GP's time' or cast them as a 'bad patient'^{193,194,196,197}. These data extend the findings of two small-scale primary care-based surveys^{199 200} in which respondents also did not perceive their problems as medical and so did not seek help from their GP.

In several papers respondents are described as 'unconvinced' or 'pessimistic' about a GP's ability to deal with mental distress – especially where this was perceived as non-medical^{193-195,197}. Some respondents questioned whether GPs had sufficient personal knowledge of their patients and the circumstances surrounding their depression to offer help¹⁹⁷, many believed the GP could only prescribe medication which was often viewed negatively (below), and respondents in one study were uncertain about the extent to which GPs are able to provide talking therapy and are knowledgeable about depression¹⁹⁷. However, the GP was sometimes viewed as a gatekeeper who could refer to other services^{195,198}. Perceptions of GPs' interpersonal skills, their degree of caring and their competence to cure were other important factors in deciding whether or not to disclose emotional problems¹⁸⁹.

Medication

Consistent with survey data, a negative perception of the use of medication for mental distress characterised most respondents' accounts^{189,193,194,197}. Respondents were concerned about potential side effects, addiction and dependency, the length of time required to complete the treatment, and argued that medication merely 'suppresses the problem', 'masks symptoms' and 'dull the wits' and as such is 'not a remedy'¹⁹³. Respondents in one study¹⁹³ regarded receiving a prescription as being 'fobbed off' by the GP and in two studies^{193,197} respondents are quoted who had deliberately not sought help from their GP in order to avoid a prescription.

Secondary care

Psychiatrists and other secondary care services tended to be feared, associated with stigma^{191,196,197}, and a loss of control or normality^{189,197}, and therefore often resisted as a final source of help^{196,197}. Rogers et al 2001 describe how respondents' fear of transition to secondary care and the meanings this would entail made them view primary care as highly preferable despite the limitations of this that they also perceived¹⁹⁷. A smaller number of respondents are reported to conceive of secondary care as potentially beneficial assimilating psychiatrists with specialists such as might be encountered for a physical complaint such as gynaecologists or oncologists¹⁹⁶.

Counselling

Professional counsellors were positively valued by respondents in several studies^{191,193-197} and were a preferred help-source despite the fact that only a small number of respondents had actually experienced counselling as a form of therapy. This was because they were seen as having more time to listen than GPs, and as providing an opportunity to talk about problems in a confidential environment. Specialist counselling in particular was also seen as more appropriate where mental distress was conceived of as a problem of everyday living rather than illness^{191,196}. The most commonly cited reservation about counselling was respondents' anticipated discomfort at sharing personal problems with a stranger^{189,196}. Other concerns were the likely effectiveness of counselling^{189,196}, the potentially negative repercussions of discussing painful events¹⁸⁹ and stigma associated with counselling¹⁹⁶. Community-based studies found younger people^{195,196} and females¹⁹⁵ had more accepting attitudes towards counselling.

Samaritans, help-lines and support groups

Respondents in one community-based study thought that a Samaritan would have more time to listen than a GP¹⁹⁶ but were of mixed opinion about how satisfactory it would be to talk to a stranger by telephone. Local support groups were rated highly because of the empathy that could be achieved through sharing experiences, however, there were concerns about confidentiality and the stigma associated with support groups.

Friends and family

Most papers focus on respondents' views about help-seeking from formal sources. An assessment of friends and family as help sources was discussed in one community-based

study¹⁹⁶. Respondents regarded friends and family as the first place to seek help. It was thought they would offer support and understanding, though it was also recognised that family units are disrupted by geographic mobility and so may not be available. There were benefits and disadvantages attributed to using friends and family as a help source. Their help was regarded as preferable to that provided by the GP on the basis that they have a personal understanding of the individual and their life situation and problems. Some also argued that it would be easier to talk openly to a friend or family member than a formal help source, while others preferred to talk to a stranger. Concerns about seeking lay group help were that they may be judgemental, lack objectivity, fail to take distress seriously, or not know how to respond. Some respondents also suggested that those who are distressed may be inhibited from seeking lay group help by not wanting to burden lay members with their problems. This perception is reinforced in another study where patients revealed an awareness of the detrimental impact on friends and family that expression of their mental symptoms could cause and therefore the problematic nature of disclosing distress to friends or family¹⁹².

Depressed respondents in two patient-based studies had sought lay group help but in practice their experiences were less positive, reinforcing some of the reservations of community respondents. They felt uncomfortable seeking help, felt a need to appear strong, and found their friends and family lacked understanding of depression, trivialised distress or would rather ignore it^{189,193}.

Summary and limitations

A number of themes not considered elsewhere emerge in these studies such as the tendency for lay people to classify mental distress outside of the realm of illness and to hold low expectations about GP's abilities to help. They also assist interpretation of issues such as 'perceived need' quantified in population surveys. Some studies introduce alternative ways of conceptualising help-seeking by depicting this as a social process and trajectory which may be long, varied and complex and influenced by the social network ^{190,197}. Table 3.16 summarises possible reasons for non-help-seeking emerging in these studies.

Community-based data inform about general lay understandings and are useful in describing the social context and belief systems within which episodes of mental distress and help-seeking occur, but they do not demonstrate if and how the themes discussed

apply in real situations. Patient studies obtain data from people with actual experiences of distress and help-seeking. They ask respondents to recount their experiences and perceptions of care and in doing so collect data relevant to help-seeking, but these data are mainly presented as general attitudes and/or without a clear indication of how the themes described actually influenced help-seeking or were negotiated. The papers less often contextualise these data with narratives of respondents’ actual help-seeking trajectories or behaviour. Few discuss the actual process of seeking help and very little data are reported about how these respondents actually became patients or of help-seeking triggers. Studies tend to consider specific aspects of the overall trajectory only such as the initial act of disclosure to mainly non-formal sources¹⁹² and the type of pathway into care but not the varying factors shaping this¹⁹⁰. It is also not clear whether the beliefs discussed predated or were shaped by an encounter with help services. The factors outlined in Table 3.16 therefore require further exploration by research focusing in-depth on the help-seeking process.

Table 3.16 Possible reasons for non-help-seeking suggested by qualitative studies

Factor identified	Study type: (community-based, patient-based, both)
Distress interpreted as social problems and therefore seen as not legitimate or worth taking to medical help sources	Both
Sufferers may experience difficulties recognising distress.	Community
Confusion (or reluctance) about how to classify the nature of distress and when this is or is not ‘normal’	Both
Emotional problems not seen as illness because they are non-physical	Both
Pathways to care are influenced by the social network.	Patient
There are practical and knowledge based barriers to help-seeking	Both
A lack of vocabulary for distress and past experience of mental health consulting creates uncertainty and anxiety about how to convey distress to help source	Patient
Cognitive disturbance disrupts communication and prevents search for help or belief in entitlement to this	Patient
Fear of labelling and stigma disrupts willingness to disclose distress and to accept treatment	Both
Seeking help compromises cultural and moral values provoking feelings of weakness, shame and felt stigma	Both
Perception that GPs: <ul style="list-style-type: none"> Do not welcome presentations of emotional distress Lack time to deal with and listen to emotional problems Are unable to provide an adequate response 	Both
Negative perceptions of anti-depressant medication	Both

Non-help-seeking respondents with disorder are not reached by these studies. They may be incorporated in community samples but if so are not identified. However, given that help-seeking trajectories can be complex and of varying nature it is likely that many respondents had also engaged in episodes of non-help-seeking.

Studies specifically of young adults

The main sources of data regarding young adults' help-seeking for mental distress are surveys sub-divided into two types: 1) dated literature focusing on university students' use of college mental health services; 2) epidemiological surveys that aim to examine psychiatric morbidity and help-seeking with representative samples of young people replicating the general population surveys described above. These data are supplemented by a small number of small-scale surveys based on non-representative populations^{20,26,201} and a large-scale survey of deliberate self harm (DSH)²².

University student surveys

Several papers ²⁰²⁻²⁰⁹, and two reviews^{210,211} present the results of surveys conducted between 1958 and 1986 with university students about their use of University mental health services. These are USA-based with the exception of one Canadian paper²⁰³. Symptom level, number of problems and feelings of unhappiness and anxiety were the best predictors of help-seeking. Compared to random student samples, help-seeking students were more likely to be female ^{203-205,210}, introspective and emotionally expressive^{204,205,207,210} and to have separated parents²¹⁰, educated fathers with high status occupations^{204,205,208,210}, and fewer close friends^{204,205,207,208}.

In these studies the comparison group of 'non-help-seekers' are comprised mainly of non-cases and so, as with whole sample analysis in general population surveys, the findings are confounded by the incidence of distress and factors associated with this. They do not demonstrate therefore differences in the characteristics of help-seeking and non-help-seeking cases, nor can they quantify non-help-seeking. They are also based on small samples and lack generalisability since they are limited to a student population – of mainly prestigious American universities²¹⁰– and those seeking help from a specific help source - university services – which is more accessible than community services²⁰³ and may attract help-seekers with specific characteristics or types of 'problem'^{204,210}.

The only exception is O’Neil et al’s²⁰³ study which identifies cases using a standardised screening tool and compares help-seekers with distressed non-help-seekers rather than a random student sample. Details of this study are shown in Table 3.17. Severity was the main predictor of help-seeking. Suicidal ideation and gender were also important. Further sociodemographic variables differentiated help-seekers and non-help-seekers where morbidity was mild or moderate.

Table 3.17: Help-seeking behaviour of depressed students - O’Neil et al 1984²⁰³:

<i>Methods</i>	
Setting: University of Toronto, Canada	
Sample: Depressed students (183 users of university clinic, 55 non-users of clinic)	
Response rate: 76%	
Screening tool: Beck Depression Inventory (BDI)	
Analysis: Comparison of characteristics of users and non-users	
<i>Main predictors of clinic use</i>	
Severity of depression (number/intensity of symptoms)	
Suicidal thoughts	
Being female	
<i>Additional predictors at moderate levels of severity</i>	<i>Not related</i>
Being older	Having a confidant
Living away from home	Parental socio-economic status
Help-seeking from a GP	

Epidemiological surveys

Eleven papers were identified that provide data about mental distress and help-seeking in young adults from surveys conducted with young people (Table 3.18)^{14-16,19,27,28,212-215}. Papers were included if the age range of their sample overlaps with that of relevance to this thesis (16-24 years). They derive from the UK, other European counties, Australia, the USA and China. Most of the studies used school samples and achieved high response rates by administering questionnaires in the classroom^{14,19,27,212-216}. Five involved a clinical interview^{14-16,212,215}. Their main focus is on assessing the prevalence of morbidity. Most attention will be given to the four papers that describe studies based on age ranges closest to 16-24 years^{14,15,27,28} (described first in Table 3.18). These are the only papers to focus entirely on young adults, though two are restricted to young adults under twenty^{27,28} and one to those aged 20-24 years¹⁴. The help-seeking data they provide are limited, since only two are specific studies of help-seeking^{27,28}, the others being prevalence surveys focusing on depression only^{14,15} and one¹⁵ is USA-based so less relevant given differences in the USA healthcare system.

Table 3.18: Epidemiological surveys of mental distress and help-seeking in young adults/ adolescents

Study	Design	Population/ setting	Sample size (response)	Diagnoses/ screening tool	Definition of help-seeking	Main findings
Potts et al, 2001 ²⁸	2-phase: (1) GP casenote review (2) postal survey	UK. 16 year olds from GP Practices. Regional, urban.	(1): 2359 (2): 99 (72%)	Psychiatric symptoms/ illness (GHQ-12)	GP consultations past year (any and for mental health)	The self-reported rate of psychiatric morbidity (past yr) was seven times greater than suggested by respondents' medical records demonstrating an iceberg of undisclosed mental distress
Aalto-Setälä et al, 2002 ¹⁴	2-phase: (1) postal survey (2) clinical interview	Finland. High school-based (mean age 21.8yrs), Regional, urban.	(1): 651 (92%) (2): 245 (61%)	Depression DSM-IV (GHQ, SCAN)	Life-time & past year use of general or speciality health services for mental health	Less than half of depressed cases had ever sought mental health care and less than a third in the past year. Help-seeking was related to comorbidity but still many severe cases had not sought help. There were no sex differences in help-seeking.
Rickwood & Braithwaite 1994 ²⁷	Questionnaire survey	Australian school-based (16-19yrs mean 17.4). Regional, urban	715 (100%)	Psychological distress (GHQ-12)	Seeking help for 'emotional problems' in last 12 weeks from formal or informal sources	Only a small proportion (17%) of cases had sought formal help but informal help-seeking from friends and family was common (60%). Gender and 'willingness to disclose' were related to any help-seeking. Severity was the only predictor of formal help-seeking.
Kessler & Walters, 1998 ¹⁵ .	Large-scale cross-sectional survey. Interviewer administered	USA 15-24 year olds in national comorbidity survey (NCS)	1769 (88%)	Depression DSM-III-R (CIDI)	Use of health, social and informal services (last year) for emotional problems	37% with major depression and 29% with minor depression had sought some professional help in the past year. Most had been treated in the speciality sector.
Gasquet et al 1997 ¹⁹	Questionnaire survey	French school-based (12-20yrs, mean 15.8). Regional, mixed	3311 (94%)	Depressive symptoms (DSS)	Consulting physician and/ or nurse for depression in past year	Respondents reporting suicidal thoughts and displaying aggressive/ delinquent behaviours were more likely to seek help.
Essau et al ²¹² , 2000.	Longitudinal study (1 st wave), Survey and interview.	German school-based (12-17yrs, mean 14.3). Regional, urban	1035 (not reported)	Anxiety disorders DSM-IV (CIDI-M) (lifetime)	Ever seeking professional help for anxiety disorder	Despite high levels of impairment, few anxiety cases had sought formal help.

Table 3.18: Epidemiological studies of mental distress in young adults/adolescents (cont.)

Wittchen et al 1998 ¹⁶ .	Longitudinal study (1 st wave). Interviewer administered questionnaire	German, 14-24yrs sampled from government registry Regional, urban	3021 (71%)	Mental disorders DSM-IV (CIDI-M) (lifetime)	Ever contacting a health professional due to mental disorder	Almost 50% of lifetime cases had at some point contacted a doctor. The prevalence of help-seeking varied by disorder being highest for panic disorder and lowest for phobias Comorbidity was associated with increased help-seeking.
Saunders et al 1994 ²¹⁶	Questionnaire survey	USA school-based (11-18yrs). Statewide, urban	17,193 (70%)	'Mental health problems' Emotional distress scale (BDI)	Professional help-seeking (past year) for 'personal problems'. Talking to informal source about problems/ depression.	Females and those with suicidal thoughts were amongst those more likely to consider they 'needed' professional help. Those with suicidal ideation, informal help-seekers, and those with separated parents were more likely to actually seek this.
Lau et al, 2000 ²¹³	Questionnaire survey	Hong Kong, school-based (14-17yrs). Regional, urban.	3355 (98%)	Anxiety/ insomnia (self-reported past 3 months)	Consulting a doctor (past 3 months) for anxiety/ insomnia	Reports low levels of help-seeking
Hesketh et al, 2002 ²¹⁴	Questionnaire survey	China, school-based (12-17yrs). Regional, mixed.	1576 (97%)	Depression and suicidal ideation (self-reported)	Any source consulted about 'feeling depressed'	Cases relied on friends and family for help and levels of professional help-seeking were very low. Approximately a third had sought no help.
Goodman & Huang, 2001 ²¹⁵	Survey interviews	USA, females 14-17yrs). National Longitudinal Study of Adolescent Health. Urban.	5735 (75%)	Depression (CES-D)	Receipt (last year) of psychological/ emotional counselling)	There was a low prevalence of help-seeking. Socio-economic status did not appear to predict mental healthcare utilisation.

The prevalence of help-seeking amongst young adults

Nine papers estimate the prevalence of help-seeking amongst distressed or disordered young adults and adolescents^{14-16,19,27,212-215}. These are summarised in Table 3.19, which demonstrates more about the difficulty of collating and reviewing these estimates than it does about the prevalence of help-seeking in young adults. Estimates are divergent, disparate and difficult to interpret for the same reasons discussed in the relation to general population surveys (above). The more relevant papers (defined above) report that less than a fifth (17%) of young adults with mental distress had sought help from a health care source (past three months)²⁷ and approximately 27%¹⁵ to 34%¹⁴ of those with depression (past year) which is lower than comparable estimates for all adults (above).

Unlike in general population surveys, an estimate of the prevalence of help-seeking from friends and family (60.1%) is also provided in one Australian-based study²⁷ revealing that distressed young adults consult lay sources much more frequently than they do formal help-sources. The estimates of help-seeking for mental distress are limited since they relate to cases defined by GHQ score rather than clinical interview which may result in the inclusion of individuals with less 'need' for help and in turn lower estimates of help-seeking.

Additional data about the prevalence of help-seeking in young adults (18-24 years) can be extrapolated from two USA papers reporting on the ECA general population survey which provide age specific data^{136,141}. Consistent with young adult surveys they report that approximately 20% of 18-24 year olds with symptoms of depression¹⁴¹ and 11% - 13.2% of those with any DSM-III mental disorder¹³⁶ sought healthcare for their symptoms during the previous six months.

The only UK data to focus specifically on the extent of help-seeking in young people²⁸ does not provide a prevalence estimate but compares the GHQ scores of a sample of sixteen year olds with the same subjects' GP casenotes over the past year. The GHQ survey suggests psychiatric morbidity is almost seven times greater than apparent from the casenotes and of the 57% of respondents who felt 'sad, unhappy or low', only 1% had consulted a GP for this reason.

Table 3.19: The prevalence of help-seeking in surveys of young adults/ adolescents

Study	Diagnosis/ screening tool	Caseness (%)	Any healthcare prof.			GP 1 year	Friends/ family		Any help 1 year	Relevance of the estimate
			3mnths	1 year	Ever		3mnths	Ever		
Rickwood & Braithwaite 1994 ²⁷ (Australia)	Psychological distress/ GHQ- 12 (threshold 4)	27.7% past 3 months	17.2%				60.1%			+: Young adults (16-19yrs) only, Australian health setting similar to UK
Aalto-Setälä et al 2001 ¹⁴ (Finland)	DSM-IV depression/ GHQ-36, SCAN	14.9% past year		34.0%						+: Young adults (20-24yrs) only
Kessler & Walters 1998 ¹⁵ (USA, NCS)	DSM-III major depression/ CIDI	12.4% past year		26.7%					36.6%	+: Young adults (15-24yrs) only. -: US health systems differs from UK
Gasquet et al 1997 ¹⁹ (France)	Depressive symptoms/ DSS	Not Reported		14.4%		12.5%				-: Wide age range (12-20yrs). Estimate is the prevalence of help-seeking in all respondents not cases.
Wittchen et al 1998 ¹⁶ (Germany)	DSM-IV mental disorders/ CIDI	27.7% (ever)			50.0 (exact % not given)					-: Adolescents and young adults (14- 24yrs). Considers lifetime disorder and help-seeking so could include childhood episodes
Essau et al 2000 ²¹² (Germany)	DSM-IV anxiety disorders/ CIDI	18.6% (ever)			18.2%					-: Sample mainly adolescents (12- 17rs), considers lifetime disorder and help-seeking so could include childhood episodes
Lau et al, 2000 ²¹³ (Hong Kong)	Anxiety & insomnia/ none	24.3% (f) 16.3% (m)	12.5%							-: No formal measure of disorder/ 'need'. Different cultural setting.
Hesketh et al 2002 ²¹⁴ (China)	Symptoms of depression or suicidal ideation / none	67.9%			0.4%			66%		-: Mostly adolescents (12-17yrs). Definition of caseness and help- seeking not clear. Different cultural setting/ healthcare structure.
Goodman & Huang, 2001 ²¹⁵ (USA)	Depression/ CES-D	17% past year		17.9%						-: Mostly adolescents (mean age 15.4 yrs), US based. Data for females only

Key: (f) = females, (m) = males

'+' denotes aspects of the study that increase its relevance to this thesis, and '-' denotes aspects decreasing the relevance

Factors associated with help-seeking

Five papers discuss factors associated with help-seeking in young adults with mental distress or disorder. Of these, three were identified as of particular relevance to this thesis^{27 14 15}. The others are a study of females aged 14-17 years and focusing on socio-economic status²¹⁵ and a French school-based survey of help-seeking for depressive symptoms amongst those aged between 12 and 20 that is restricted to the whole sample approach (above)¹⁹.

Gender and other sociodemographic factors

Like general population surveys of all adults, young adult surveys suggest that females with mental disorder are more likely to seek help than males though data are limited. Kessler & Walters 1998¹⁵ report that of those young adults (15-24yrs) with major depressive disorder, just 18% of males compared to 31% of females sought some form of healthcare. In contrast, Aalto-Setälä et al 2002¹⁴ found similar proportions of male and female depressed cases had sought help in the past year, but the study was too small to detect sex differences, the sample consisting of just 53 cases of whom only 10 were male. Other studies suggest that young females seek more help from their lay group but not from health professionals. Rickwood et al 1994²⁷ report from multivariable analysis of GHQ cases that total help-seeking and seeking help from friends and family was related to being female, even when controlling for symptom severity, though gender did not predict whether respondents sought help from professional sources instead of just lay help sources. Adding to these data, two further small-scale surveys of young adults with mental disorders report that significantly more females than males had spoken to a friend but that similar proportions had spoken to a GP^{26,201}.

In two studies, socio-economic status did not predict help-seeking for depression^{19 215}, although there were associations between seeking help from a health care professional and having parents that are not living together (OR 1.9), and age – adolescents were less likely to seek help than young adults¹⁹.

Morbidity factors

Rickwood et al²⁷ consider the association of symptom score (GHQ) and help-seeking amongst GHQ cases in the only paper to explore the influence of symptoms in 'cases only' analysis. Severity (GHQ score) increased the likelihood of help-seeking from a

professional source, but not *total* help-seeking (professional and informal sources combined). This was the only significant predictor of professional help-seeking amongst GHQ cases. Gasquet et al¹⁹ examined the influence of specific symptoms in the whole sample on the likelihood of consulting and found that respondents experiencing suicidal thoughts 'fairly' or 'very' often sought more help than those 'never' or 'occasionally' thinking of suicide (OR 2.9) but still 60% of depressed and suicidal respondents did not seek help. Other specific symptoms measured (concentration, self-criticism) were not significant in multivariable analysis.

Aalto et al¹⁴, focusing on 20-24 year olds with depressive disorders, report an association between help-seeking and increasing severity of disorder measured by 1) existence of co-morbidity, 2) the degree of impairment associated with disorder, and 3) 'need for psychiatric care' as estimated by the researcher on the basis of available clinical data. Of these variables, co-morbidity was the strongest predictor - 50% of co-morbid cases compared to just 10% of single diagnosis cases sought help. Although severity may increase consulting, the authors draw attention to the fact that of those with serious impairment, only a third had sought help. They also speculate that duration may be an important variable since those respondents with dysthymia had higher rates of help-seeking than those with other depressive disorders, but these findings are limited as they are based on just 53 cases.

Gasquet et al¹⁹ found that aggressive and delinquent behaviour, school absenteeism, and the use of alcohol and illicit drugs showed some relationship with help-seeking but only school absenteeism remained an important predictor in a multivariable model.

Personality and social network factors

Rickwood et al²⁷ investigate the association of help-seeking with a range of personality and social network factors. The only personality factor to increase the likelihood of (any) help-seeking amongst GHQ cases was 'willingness to disclose mental health status' indicating the individual's degree of openness with others regarding their psychological or personal problems. However, this variable is not particularly explanatory since it simply seems to describe tautologically a facet of help-seeking. Social network variables showed no association with help-seeking or the type of help sought by GHQ cases.

Summary

There is a clear lack of help-seeking data on young adults. No UK data providing specific estimates of the prevalence of help-seeking by young adults were identified. University-based studies are extremely limited in terms of representativeness, study design and date. More recent surveys also have methodological limitations. Compared to surveys of all adults, they are based on smaller samples and so have fewer 'cases' for analysis. They are also hampered by variations in study design and definitions. In addition the range of ages considered frequently straddles adolescence (12-16 years) and young adulthood (16-24 years) despite the vast differences in maturation across these stages and the implications that this may have for pathways into care. Most studies tend to be skewed towards adolescence – the mean age of respondents being less than 16. Based on the limited available data the following preliminary observations can be made:

- Prevalence estimates suggest that a fifth or less of young adults with mental distress or disorder seek formal help and between a quarter and a third of those with depression (the disorder associated with the highest rate of help-seeking general population surveys). This is considerably lower than estimates for adults of all ages.
- Help-seeking from friends and family appears to be more common than professional help-seeking - similar to the one estimate available for all adults – and more prevalent amongst females.
- In keeping with surveys of all adults, being female, severity of disorder, suicidal thoughts and co-morbidity appear to predict help-seeking in young people, though again attention is drawn to the low prevalence of help-seeking even amongst those with severe disorder. Over half of those with co-morbidity and suicidal thoughts had not sought help.

Illness behaviour and qualitative data

Data addressing young adults' illness behaviour in relation to mental distress are even more scant. Just one of the surveys described above incorporate such variables²¹⁶. This is supplemented by a large-scale survey focusing on self harm²² and three small-scale non-representative surveys with limited qualitative data^{20 201 26}.

Perceived need for help

Issues surrounding the perception of need for help are examined in two surveys – one focused on ‘cases’ aged 12-18 years (Saunders et al 1994²¹⁶) and the other on USA psychology students aged 18-20 years (Padesky & Hammen, 1981²⁰¹). Saunders et al 1994 found that half of their cases perceived a need for help but the study was based on self-defined caseness rather than formal screening criteria thus relying on a further interrelated act of perception – the perception that a problem exists – potentially exaggerating the degree of perceived need. No information is provided about morbidity against which to assess respondents’ definitions. Factors positively associated with perceived need were being female, being white, severe suicidal ideation (BDI scale), self-rated poor general health, and a perception of low parental care, while having parents who were married or less educated were negatively associated.

In this study, only 46% of the respondents perceiving a need for help actually sought this. Help-seeking was more likely amongst cases with parents with higher education and social class, and who were divorced or separated and where the individual reported using informal support such as friends and family (OR 1.7, $p < 0.001$) – particularly where a family member was their preferred informal source. This may represent parental involvement in obtaining help for adolescents rather than independent help-seeking by young people. Notably, those with less suicidal ideation were more likely to seek help than those with severe ideation and respondents who had *not* thought of suicide were nearly two times more likely to seek help than those who reported ‘I would like to kill myself’. The authors suggest this indicates the existence of ‘substantial barriers to seeking help associated with suicidality’ but do not elaborate upon what these might be.

Padesky & Hammen²⁰¹ asked respondents (cases and non-cases) about the severity of depression (rated on a five-point scale) at which they would consider it necessary to seek help. Both males and females thought they would have to be ‘very seriously depressed’ to seek help from a doctor (mean score for males and females = 4.7). Males reported that they would need a higher level of severity than females before they would seek any help (males 3.9 v. females 3.7, $p < 0.05$) and help from a friend (male 3.4 v. female 3.0, $p < 0.001$). However, it is not possible to tell whether these differences relate to actual differences in the perception of need, or alternative explanations such as a male reluctance to seek help or barriers created by gender-related social attitudes about when and for whom help-

seeking is acceptable. Also, as the study does not provide data about actual help-seeking and severity it is not known whether these differences would persist in a real situation.

Barriers to help, coping and preferred help sources

Data about barriers to help-seeking and coping strategies are provided by Hawton et al 2003, in relation to DSH amongst 15-16 year olds²² and from a Samaritans survey conducted with a self-selecting group of young men (aged 13-19 years) responding to a questionnaire published in The Express newspaper²⁰.

Gender stereotypes were cited frequently by depressed or suicidal young men in the Samaritans survey²⁰ as barriers to seeking help. These were social values transmitted by peers and also older men, including fathers, about how a man should respond to emotional problems. The pressure to appear 'manly' precluded seeking help from others, promulgating the attitude that males should cope with their problems alone. Hawton et al 2003 considered barriers to using the Samaritans and found that embarrassment, lack of confidence, fears about confidentiality and a concern that problems were too trivial were the main reasons given for not seeking help²².

Over two-thirds of suicidal and depressed respondents in the Samaritans survey²⁰ reported a perception of having nowhere to turn to for emotional support or help. Few considered help-seeking as a means of dealing with their distress and there was an absence of positive coping strategies. Instead, common means of coping with distress amongst those who were depressed were: stay in my room (34%), smash something (17%), take an illegal drug (15%), have a drink (17%), or smoke (20%). These results are mirrored in Hawton et al's survey of self-harmers²². In this study, friends and parents were the preferred help sources but formal help sources were rarely approached. Young people's preferences for informal, lay help and the greater frequency with which such sources are consulted has also been noted in more generic studies of help-seeking for stressful events, educational problems or feelings of ill-health (mental and physical)²¹⁷.

Qualitative data

Limited qualitative data are provided in the form of a Mental Health Foundation (MHF) research report²⁶. This describes data obtained from young adults aged 16-25 years in questionnaires (n=35), face-to-face interviews (n=20) and focus groups (n=10). Participants were service users recruited via health professionals. The main aim of the

research was to gain insights from users to improve service provision rather than exploring routes into care so data relating to help-seeking are minimal. Key questionnaire findings followed-up qualitatively were that:

- Over 50% of respondents had not identified their problems before a crisis such as a suicide attempt or major depressive episode had occurred.
- Most who tried to seek help experienced difficulties obtaining it.
- Many respondents were critical of GPs as a source of help.
- A third had initially turned to family members for support.

In qualitative interviews, respondents accounted for their lack of perception in several ways. For some, their illness had developed gradually and without them realising, others had believed that they were in control of their feelings, some attempting to cope via self-harm. Some respondents also cited lack of knowledge or previous experience of mental health problems as a reason. Confirming this, previous experience was an indicator of a developing crisis for other respondents.

Many respondents felt there were few places they could obtain support. In some instances, family members or other lay sources had denied that a problem existed and respondents conveyed a general belief that professional help was difficult to access. Barriers experienced were: belief that GPs lack understanding and interest and are reluctant to provide support; difficulties with service provision such as services being too busy or not operating out of hours; and reluctance to turn to mental health professionals on the basis that they are intimidating. However, it is difficult to disentangle from these data pre-existing perceptions and respondents' subsequent evaluations of their encounters with professionals.

Summary

The majority of the literature identified by this review is quantitative and epidemiological and is of limited relevance to understanding the particular situation of young adults. It reveals that approximately a third of adults with mental disorder seek formal help for this (mainly from a GP). However, few studies quantify informal and lay group help-seeking. Severity of disorder and co-morbidity appear to be the main predictors of help-seeking, and also gender - females seeking more help. However, a

tendency to analyse factors associated with help-seeking amongst the whole survey sample rather than only cases limits the interpretation of much data. Surveys of illness behaviour suggest that failure to perceive a need for help or the feeling one should be able to manage alone are main barriers to help-seeking. Only limited qualitative data are available. Themes emerging from these are: a tendency to classify mental distress as social problems rather than illness and therefore to consider medical help-seeking inappropriate; stigma; a low perception of GPs' ability to help; feelings of weakness and shame associated with help-seeking; negative perceptions about the use of medication; the complexity of pathways to care and lay involvement in these. Qualitative studies have been conducted with general population samples, or patients – but not non-help-seekers, though patients may have engaged in periods of non-help-seeking before seeking help.

While there is a clear lack of empirical data focused on help-seeking in young adults, surveys of all adults suggest young adults:

- Have lower odds of help-seeking than adults aged 25-54 years
- Are less likely to perceive a need for help
- Are more likely to report embarrassment as a barrier to help-seeking
- Are less likely to endorse the GP as a useful source of help
- Are likely to suggest socialising and risk-taking behaviour as means of coping with distress

Such indications require more exploration. Further qualitative understanding of help-seeking behaviour is also required. These were the aims of this thesis. The next chapter describes the methods used to achieve this and subsequent chapters report the findings.

CHAPTER 4: STUDY DESIGN AND METHODS

Introduction

The previous chapters have provided the background to this research. This chapter describes the study design and methods. The study used mixed methods and involved two components – a cross-sectional survey and qualitative interviewing. The chapter discusses each component and how they were linked. It also outlines the process of piloting and explains the rationale for the chosen design.

Study design

The study combined quantitative and qualitative methods. A quantitative cross-sectional population survey was used to assess the prevalence of disorder and help-seeking and to collect data about factors associated with help-seeking behaviour. This was accompanied by in-depth qualitative interviews with a selection of help-seeking and non-help-seeking survey respondents who screened as cases of mental disorder, which sought to understand the reasons for observed patterns of help-seeking. Interviews explored lay concepts of mental disorder, beliefs about help-seeking, perceptions of help sources and collected narratives of illness behaviour accompanying respondents' episodes of mental distress. The survey and interviews were carried out simultaneously to ensure that survey 'cases' were followed up while their self-reported mental distress remained accurate. Two screening tools were used in the study: 1) the 12-item General Health Questionnaire (GHQ-12)²¹⁸, which was included in the questionnaire as a population screen to identify 'cases' with probable mental disorder; 2) the Clinical Interview Schedule (CIS-R)³² - a diagnostic tool that can provide a more accurate and detailed assessment. This was administered to those recruited for qualitative interview to ascertain the level of disorder experienced.

The research was supported by a grant from South West NHS Research and Development Directorate. Ethical approval was obtained from the relevant local research ethics committees – The United Bristol Healthcare Trust (UBHT), North Bristol NHS Trust (Frenchay and Southmead), and Weston Area Health Trust. The study questionnaire and interview topic guide were developed during a pilot study involving

qualitative interviews with twelve young adults randomly selected from the patient lists of three local general practices.

Mixed methods

‘Mixed’ or ‘multi’ methods have been defined as “the use of qualitative and quantitative data collection and analysis techniques in either parallel or sequential phases”²¹⁹. There is a contemporary trend towards the use of such designs, particularly in health services research, and a critique of previous tendencies to polarise the two approaches and stress their incompatibility on account of opposing epistemological and methodological assumptions^{219,220}. Pragmatism is a driving force for mixed method designs, that is, the need to apply differing approaches capable of obtaining differing data in order to address complex, multifaceted research questions^{219,220} posed in applied areas of research, such as public health²²¹ and health services research²²². The rationale for using mixed methods revolves around the opportunity to capitalise on the relative strengths of each approach: quantitative research to contribute generalisable findings and qualitative research to add meaning, explanation and appreciation of social context. The two approaches allow varying aspects of the phenomena to emerge, making it possible to gain a multi-layered understanding. Mixed methods therefore facilitate ‘expansion’, that is, they add scope and breadth²²⁰.

Quantitative and qualitative research may be combined in differing ways. At the extreme this may involve total integration from data collection, through to interpretation employing such strategies as quantifying qualitative themes and ‘qualitizing’ quantitative data²¹⁹. However, an attempt to merge the two to this degree calls into question whether the defining qualities and therefore strengths of each are preserved or compromised in the process²²³. Alternatively, the two approaches can be used in ‘complementarity’ where they are used separately to tackle different aspects of the research question²²⁴. It was in this sense that a mixed methods design was used here.

Quantitative research was used to measure the scope and parameters of the problem of non-help-seeking for mental disorder amongst young adults with the aim of producing representative data similar to that currently existing in relation to all adults (chapter 3). As noted in chapter 3, adequate understanding of reasons for non-help-seeking is currently lacking, though such understanding is central to any attempt to challenge barriers and devise interventions to establish more appropriate illness behaviours.

Qualitative methods - being concerned with holism, the implicit and explicit, individuals' perceptions, meanings, social worlds, and action²²⁵ (table 4.3, below) - were employed to address this omission and to investigate help-seeking in the context of young adulthood and explore help-seeking as a social *process* and trajectory. The relevance of using mixed methods in this study was reinforced by the example of Rogers and Nicolaas 1998²²⁶ who, citing Pescosolido et al, used mixed methods to understand healthcare utilisation to reveal how structure and agency together influence help-seeking and therefore the complexity underlying illness behaviour.

The quantitative and qualitative components of this study were conducted simultaneously but also independently, each according to the conventional standards and approaches of that method and with specific objectives (below). They were interwoven in the sense that the quantitative survey provided a sampling frame for qualitative interviews by identifying respondents with mental disorder and also making available respondent characteristics that were used purposefully to obtain a maximum variation sample. This included the addition of some open-ended questionnaire items that could indicate respondents with particular views or who had engaged in alternative illness behaviours that appeared of potential theoretical interest. An attempt is made to combine the quantitative and qualitative findings at the phase of interpretation (chapter 8) following the example of others who have implemented this approach²²⁷. Further, this main research was preceded by qualitative pilot interviews during which both the quantitative questionnaire and qualitative interview topic guide were developed.

The pilot study

Twelve interviews were conducted for the pilot study. Three local GPs were asked to provide a random sample of young adults (16-24 years) who could be approached for interview. These GPs were chosen because they were known to one of the project supervisors (DS) and had an interest in mental health. All agreed to assist. Their practices were located in differing areas of Bristol with varying socio-economic characteristics. Patients aged 16-24 from each practice were listed in numeric order, stratified by age and gender, and a random sample selected. An equal number of individuals were sampled from each strata at the first practice but, at the second and third, sampling was more purposeful to increase the chances of successfully recruiting both genders and a range of ages. Sampled individuals were sent a recruitment letter

signed by the GP (Appendix 1) and an information sheet (Appendix 2). They were asked to return a reply slip indicating whether or not they were willing to be interviewed. Recruitment continued until young adults with a range of characteristics had been interviewed and it was demonstrated that the questionnaire and interview topic guide had been satisfactorily refined to proceed with the main research.

In total, 47 young adults (24 males, 23 females) were sent recruitment letters resulting in 12 completed interviews (25.5%), 3 refusals and 32 non-responders. Only one refuser gave a reason ('lack of time'). Males of both age groups were most difficult to recruit. Table 4.1 summarises the characteristics of interviewees.

Table 4.1: Characteristics of pilot study interviewees

CHARACTERISTIC	N
GENDER	
Male	4
Female	8
AGE	
16-19yrs	8
20-24yrs	4
RESIDENCY	
Parents	5
Friends	2
Spouse/ partner	3
Alone	1
Boarding house	1
OCCUPATION	
Student	5
Employed	7
MORBIDITY	
GHQ-12 case (score 4 or more)	3
Past account of mental distress	2

Individuals who agreed to interview were contacted by phone to arrange a time and venue. Interviews were conducted either at the participant's home or the university. Before the interview commenced, interviewees were required to sign a consent form as in the main research study (Appendix 3). Interviews then followed a semi-structured format guided by completion of the draft study questionnaire, the use of case vignettes about mentally distressed young people, and a draft interview topic guide.

First, respondents were asked to complete the draft study questionnaire and comment on this. As well as investigating the general acceptability and accessibility of the questionnaire²²⁸, this exercise also had a number of specific aims. These were to:

- Gauge responses to a questionnaire about mental distress, suicidal ideation and help-seeking behaviours and explore the most appropriate terminology by which to describe this subject matter.
- Test that the GHQ-12²¹⁸ could be used by a young adult population and to consider the possibility of incorporating a second screening measure (The Perceived Stress scale PSS²²⁹).
- Test GHQ-28²³⁰ suicide sub-scale questions in order to ascertain which could be incorporated in the questionnaire to explore suicidal thoughts.
- Pilot the help-seeking questions since these had not been tested elsewhere.

The questionnaire evolved throughout the process of piloting with adjustments being made until reaching a format that was easily completed by interviewees. This involved dropping some questions, clarifying ambiguities, changing the order of questions and improving formatting. Respondents did not object to the questionnaire content. Early drafts of the questionnaire used the term 'stress' to address mental health but it became apparent that this had a very broad and generic meaning and therefore did not discriminate everyday experience from more significant 'distress' as required. In contrast, the term 'mental health problem' or 'mental illness' suggested unusually extreme distress. 'Psychological health' and 'psychological problems' emerged as the most acceptable terminology indicating to respondents something between these extremes. Interviewees did not query the meaning of this terminology and when asked what they considered it to mean gave consistent responses including; '*your mind and thoughts*', '*emotions*' and '*feeling depressed*'. This was therefore adopted throughout the questionnaire.

No interviewees had difficulties in completing the GHQ-12. The PSS was dropped because it significantly increased the questionnaire length and completion time, re-framed the overall theme of the questionnaire (and subsequent discussion) towards generic, everyday experiences, and its data were therefore of little use. Two respondents reacted to the GHQ-28 questions addressing suicidal thoughts describing these as '*hard-hitting*' and potentially '*insensitive*' but the majority did not share this opinion. Several

respondents did not understand one question ('Have you recently thought of the possibility that you might make away with yourself') and so this question was dropped resulting in four GHQ-28 suicidal ideation questions being incorporated in the final questionnaire. Early interviews revealed that respondents had differing definitions of the term to 'seek-help' used in the questionnaire. To achieve consistency the meaning was clarified by stating that help-seeking could also include advice seeking and indicating that this could be the informal/casual (eg. from friends and family), or formal (e.g. from a GP).

A second aim of the pilot interviews was to develop an empirically grounded preliminary topic guide for the main study interviews. This was achieved through general discussion of issues surrounding mental health and help-seeking. Initially, this was influenced by a topic guide based upon the main themes in the existing illness behaviour literature and models of utilisation (Chapter 2). This topic guide was then refined with each interview to incorporate emerging themes relating to mental distress and the context of young adulthood. While interviewees were encouraged to discuss their own experiences of mental distress and help-seeking or those of other people that they knew, as anticipated, few had such experiences due to the random nature of sampling. This was not problematic since case vignettes had been designed for use in the interviews to act as a substitute for personal narratives of distress and as a device to prompt and facilitate focussed discussion²³¹.

Case vignettes are hypothetical but socially situated stories that can be used in an unthreatening way to explore general beliefs, understandings, and attitudes towards often sensitive issues²³¹⁻²³³. Four vignettes were designed for the pilot interviews (appendix 4), two being used in each interview. They were designed with reference to DSM and ICD criteria for mental disorders^{234,235}. Each vignette described a young person with symptoms of mental distress and was set within the context of young adulthood including typical problems such as relationship difficulties, study pressures and unemployment, and incorporating reference to peers and parents. A quasi-real situation was described and respondents were required to mimic aspects of illness behaviour within this context by discussing what might be wrong with the character in the story, how they were likely to respond, and what they thought the character should do in response. In particular, the vignettes were used to explore issues surrounding symptom recognition and evaluation, preferred coping strategies and triggers to help-seeking,

attitudes towards those who are distressed and seek help, and understandings about the causes and trajectory of distress. The characters were also given de-genderised names so that gender assumptions about mental distress and help-seeking could be explored.

Some of the main methodological difficulties that have been discussed in relation to the use of case vignettes apply to their use in surveys rather than qualitative interviewing^{232,233}. The gap between hypothetical and real responses was partly bridged by asking respondents directly to discuss the difference between what they perceived to be the 'correct' answers and what they thought a person and they would do in reality²³². At the end of the pilot phase a useable topic guide with both theoretical and empirical grounding had been developed to use in the main interviews.

Quantitative Population Survey

The quantitative component of the study involved a cross-sectional population survey of young adults. A postal questionnaire (appendix 5) was sent to 3004 young adults (aged 16-24) randomly sampled from the local Health Authority population register. The survey protocol and questionnaire design were informed by the pilot study described above, a review of the existing help-seeking literature (Chapter 3) and discussions with Somerset Health Authority researchers who had recently conducted a large psychiatric morbidity survey.

Survey objectives and design

The survey had three main objectives:

1. To gain population estimates of the prevalence of mental disorder and of help-seeking for mental disorder from a random cross-section of young adults.
2. To collect sociodemographic and morbidity data in order to allow a quantitative exploration of patterns of help-seeking amongst young people with mental disorder and possible factors associated with this.
3. To identify respondents with experiences of mental disorder for recruitment for in-depth interview (see below).

Additionally, a vignette of a mentally distressed young person and open-ended questions about diagnosis and appropriate illness behaviour were included to obtain

insight into lay understandings from a large sample of young people and to reveal issues for possible follow-up in interviews.

A population survey approach was selected because it offered the opportunity to identify those *not* in contact with any type of service (non-help-seekers). It was the only means of producing an estimate of the percentage of young adults not consulting for mental disorder and investigating factors associated with this. A population approach also improved the chance of obtaining a representative sample free from the potential biases introduced by doctors' diagnostic and treatment practices, and the gender patterning of self-harm or help-seeking behaviour. A population survey therefore could assess the scope of the problem and generate a descriptive context within which to conduct and develop qualitative work. Further it could provide a broad sampling frame for the qualitative study, identifying help-seekers, non-help-seekers and those who had sought help from alternative sources such as the voluntary sector.

Sampling

The target population was males and females aged 16 – 24 years from all social backgrounds. The local health authority – then Avon Health Authority (AHA) - population register was used as a sampling frame. This listed all individuals registered with a doctor (GP) practicing in Bath and North East Somerset, Bristol, North Somerset, and South Gloucestershire (figure 4.1) and included those from inner city, urban, suburban and rural areas. It included those who had never or rarely consulted. In 2000, when the sample was drawn, AHA's boundaries covered a population of approximately one million people. The region has above average socio-economic conditions compared to England and Wales but includes areas of deprivation. The 1994-6 Health Survey for England^{236,237} data show that a smaller proportion of people in Avon reported poor or bad health compared to England overall and that psychiatric health in Avon measured by the GHQ-12 did not significantly differ from the national average. In 1995-1997 there were fewer suicides in Avon (7.3 per 100,000) than the national average (9.1 per 100,000). People in Avon consulted their GP at the same rate as reported in the national 1991-2 GP Morbidity Survey^{238,239}.

Figure 4.1: The geographic region covered by Avon Health Authority



The use of the AHA population register therefore ensured that the sample was drawn from a diverse population and that questionnaires were sent to a representative cross-section. Additionally, recruitment letters and the questionnaire could be sent directly from the researcher using university headed paper and without endorsement from a GP or other help source. Although in other studies such endorsement is often used to improve response, in this case it was considered important that GPs or other help sources were not directly associated with the study to avoid any possibility that this might deter deliberate non-help-seekers from responding.

Sample size

The sample size was estimated to ensure that the survey would be adequate to yield up to forty individuals with mental health problems who would agree to participate in in-depth interviews. This calculation was informed by available data about young adults' psychiatric morbidity, help-seeking, and survey response rates from the published literature^{18,27} and a recent psychiatric morbidity carried out in a neighbouring Health Authority²⁴⁰. For the most conservative estimate, the calculation was based on male

response and morbidity rates (as measured by the GHQ) since these are lower than in females. It was estimated that approximately 55% of males would respond to the questionnaire, that approximately 10% would score above the threshold of 4 on the GHQ-12 and that of these 30% would agree to interview. On the basis that 40 interviews would be required, the estimated sample size was therefore: $40 / (0.55 \times 0.1 \times 0.30) = 2424$. To allow scope for error and to ensure that the required number of interviewees could be attained easily, the target sample size was set at 3000 individuals. A sample of this size would also enable a reasonably precise estimate of the proportions of responders with mental disorder who do and do not seek help – for example the 95% confidence intervals around a point estimate of 33% would be 31% to 35%.

The sample was randomly selected by AHA staff using an in-house computer system. A sampling frame of all 16-24 year olds on the register was generated by identifying all individuals whose date of birth fell within the specified range. These individuals were listed by general practitioner (GP), each GP listed in alphabetical order. Every 30th individual was then selected resulting in a total sample of 3087 young adults being generated. As the questionnaire was administered in batches over a period of ten months (see below), from the second batch onwards it became necessary to check that sampled individuals had not since been removed from the register as this would indicate either death or mobility outside of the region. Throughout the course of the study 83 sampled individuals were removed from the register. These individuals were therefore excluded from the study leaving a sample size of 3004, which satisfied the requirements of the sample size calculation (above). The exact reasons for their removal was not available but the most likely reason was movement out of the Avon Health Authority area. In keeping with this, those excluded tended to be older - two thirds were 20 years or more. Similar numbers of males and females were excluded (males=40, females=43).

Questionnaire Administration

The survey questionnaire was posted to those sampled with a covering letter (Appendix 6) and postage paid return envelope. Questionnaires were posted in a printed envelope with boxes that could be ticked in the event of failed delivery to indicate the reason for return. Individuals were asked to return the questionnaire blank if they did not wish to participate and were invited to add their reasons for refusal should they wish to do so. Non-responders were followed up with two reminders. The first - a reminder postcard

(Appendix 7) two weeks after the initial questionnaire mailing and the second, two weeks later, another copy of the questionnaire with a reminder letter (Appendix 8) and return envelope. Questionnaires were anonymised by means of an i.d. number. This was used to log returns and store data. To comply with the 1998 Data Protection Act, the survey was administered by the researcher and a clerical assistant at the Health Authority. An address label was attached to each questionnaire so that consenting responders could be contacted for interview. A few respondents (less than 1%) removed this label and so were not available for follow up. Eight respondents returned their questionnaires unsigned. These were destroyed and excluded from the study.

The survey was administered in five batches, each consisting of approximately 600 individuals and extended over a period of 10 months. A benefit of this was that questionnaires were sent out at varying times of the year, which went some way towards balancing the possible seasonal variations in levels of mental distress and suicidal thoughts. The administration of five smaller batches was also more manageable. The primary reason for this approach, however, was methodological. A main purpose of the questionnaire was to screen respondents to identify current ‘cases’ with probable disorder for interview. The screening device used, the General Health Questionnaire (GHQ), is a temporal measure sensitive to changes in feelings over the short period of a few weeks. It was therefore important to follow up individuals soon after the completion of their questionnaire while their self-reported mental state remained relevant so that interviews could be conducted within the context of the feelings described. Conducting the survey in five smaller batches made it easier to achieve this. The batch design also facilitated the cyclical approach to qualitative interviewing and analysis required by grounded theory, which was used to guide the qualitative component of the research (below). The timetable of data collection is show in table 4.2

Table 4.2: Timetable of data collection

Survey administration			Interviews
Batch	Initial mailing	2 nd Reminder date	
1	11/12/00	17/01/01	1 – 5 (Feb & March)
2	7/02/01	12/03/01	6 – 8 (April & May)
3	19/04/01	22/05/01	9 – 13 (May & June)
4	21/06/01	20/07/01	14 – 17 (Aug)
5	31/07/01	28/08/01	18 – 23 (Aug – Sept)

The questionnaire

The study questionnaire (Appendix 5) included newly devised questions and two standardised schedules – the 12-item General Health Questionnaire (GHQ-12)²¹⁸ with additional questions about suicidal thoughts from the GHQ-28²³⁰ to screen for psychiatric morbidity, and the Duke-UNC- Functional Social Support Questionnaire²⁴¹. It covered the following areas: socio-demographic characteristics and social support; general health and psychiatric morbidity; help-seeking; and illness behaviour.

Socio-demographic characteristics and social support

Sociodemographic characteristics and social support data were collected for analysis of the factors associated with patterns of help-seeking. These are the main ‘pre-disposing’ factors cited in theoretical models of service use (Chapter 2) and have been important in empirical studies (Chapter 3). Those collected were:

- Age - to explore whether differences exist in help-seeking across the study age range, particularly given the changes in maturity and independence occurring between the ages of 16 and 24.
- Gender.
- Residency (whom the respondent was living with). Surveys of all adults identify marital status as important to help-seeking (Chapter 3). Residency was intended to represent this in a format applicable to young adults.
- Occupational status.
- Socio-economic position - measured by parental social class and Townsend score.
- Social support.

Measuring the social class of young adults presents difficulties since traditional indicators are less applicable to this age group, particularly the younger of those included in the age band. Measuring educational attainment is difficult where individuals have not completed their education and meaningless where they are still in compulsory education. Assessing occupation is complicated by the extension of education and the trend towards ‘gap years’, and an individual’s first job may bear little resemblance to their occupational destination^{242,243}. Young adulthood also straddles the

transition from dependency to independence so an attempt to apply 'individualistic' indicators of social class could lead to inconsistency where older or independent respondents are assessed according to their own 'class' during a transition phase while those who were still dependent are assessed on the basis of parental social class. The conventional approach therefore has been to measure social class via parental occupation while an individualistic approach has only been applied where surveying young adults of twenty years or older²⁴². A further reason for studying class of origin is that childhood factors are linked to health status in early adulthood²⁴². The same might also be supposed about the transmission of health behaviours such as help-seeking. The conventional approach was therefore adopted here.

The questionnaire collected sufficient information about parental occupation to assess social class background using the UK ONS Standard Occupation Classification (2000)^{244,245}. Occupations are classified into nine main groups according to skill, specialism and level - taking into account the qualifications, training and experience required to competently perform the role - and also employment status and seniority, distinguishing the self-employed, managers and employees. Respondents were asked to supply information for the main lifetime occupation of the family's primary wage earner since it was thought that this would represent most adequately class origins and avoid difficulties posed by those who had retired. Where respondents gave insufficient information to determine an exact coding, the lower occupational level was selected. In analysis, the levels were combined to distinguish between non-manual (social classes I-IIINM) and manual (social classes IIIM-V) class origins.

A second measure of socio-economic position was also available for all sampled individuals: Townsend score²⁴⁶ - an area of residence based measure of socio-economic deprivation which was obtained by extrapolating residential postcode data and mapping this to electoral ward (see Middleton et al 2004²⁴⁷). Townsend score assesses material deprivation at ward level on the basis of data about house and car ownership, unemployment, and household overcrowding obtained from the census. Along with gender and age this was one of the few variables available to assess the characteristics of non-responders as well as responders, although it has limitations - some respondents being assessed according to parental residence and others on the basis of temporary residences or university accommodation.

Perceived levels of social support were measured using the Duke-UNC functional social support questionnaire²⁴¹ (question 16). This was included because the role of the lay group in influencing illness behaviour and acting as an informal help source has been widely discussed in illness behaviour theory (Chapter 2). The Duke-UNC was selected as it assesses qualitative and functional aspects of social support such as care giving and supporting, which appear directly relevant to help-seeking, while many other scales measure the size of the social network but not the meaning or quality of these relationships²⁴⁸. Also, the Duke-UNC is short (eight items), self-completed and recommended for use in general population studies²⁴¹. It assesses two dimensions of support providing a separate score for each: 1) confidant support (score range 5 to 25), which refers to “confiding relationships where important issues and life events are discussed”; and 2) affective support (score range 3 to 15), which refers to “emotional support and caring”. The reliability and validity of the scale has been documented²⁴¹.

General health and psychiatric morbidity

General health status was measured by asking respondents to rate their health on a five-point scale ranging from excellent (1) to poor (5). This was intended as a basic measure of the individual’s perceived health status for the purpose of exploring how perceived health status is related to mental symptoms and help-seeking by those with mental distress.

All respondents were screened for psychiatric morbidity using the 12 item General Health Questionnaire (GHQ-12) – a well validated, standardised and extensively used schedule designed by Goldberg (1972)²⁴⁹ to detect ‘cases’ with probable minor mental disorder in the community. This was the primary measure of psychiatric morbidity used in the survey. To assess psychiatric morbidity further, the questionnaire also measured:

- Suicidal thoughts (GHQ-28)²³⁰.
- Self-rated ‘usual’ psychological health on a scale from good to very poor.
- Current and past self-reported emotional or psychological problems.
- Current and past use of ‘medication’ (prescribed or otherwise) for emotional/psychological problems.

Screening was used to identify all survey respondents with probable mental disorder thus differentiating ‘cases’ from ‘non-cases’. This formed the basis of prevalence

estimates of psychiatric morbidity and help-seeking, and defined 'cases' whom it was considered relevant and meaningful to define as help-seekers or non-help-seekers whose help-seeking behaviour could be explored in quantitative survey analysis and qualitative interviews. In effect, the population screen was the means of defining according to clinical criteria a threshold of 'need' at which point help-seeking could be regarded as reasonable and potentially beneficial. The validity of the quantitative analysis and qualitative sampling was therefore somewhat reliant on that of the screening tool and so selecting an appropriate measure was central to the development of the study questionnaire.

Numerous tools exist for the assessment of mental distress in adults^{250 251-253} but few have been used widely. These have been reviewed by Bartlett and Coles (1998)^{252 253} who divide the various measures into three categories: psychiatric epidemiology, stress studies, and subjective well-being. They conclude that instruments from the field of psychiatric epidemiology, and in particular the GHQ, appear to be the most useful as these are based on clinical criteria while those in other categories are imprecise with regard to what they measure and suffer from methodological and conceptual difficulties. A literature search was conducted for screening tools specifically designed for use with young adults. Most of the records retrieved were rejected because they referred to children or younger adolescents and did not directly measure mental health but 'life events', 'stress', or 'delinquency'. One tool was identified - the 'Young Adult Self-Report' (YASR) schedule²⁵⁴⁻²⁵⁶ - an American based self-report questionnaire for those aged 18 to 28 years. In addition to mental distress, it includes items covering a broad range of social and behavioural problems producing a general measure of 'maladjustment' rather than a specific measure of mental disturbance. When compared to the GHQ-28, the YASR showed no greater potential to detect mental disorder²⁵⁴.

The GHQ therefore emerged as the most appropriate option. It is UK-based and was designed to detect: 1) current neurotic disorder amongst respondents in community settings, and 2) symptoms that may have relevance to medical consulting²¹⁸. Its setting and aims therefore match well those required in this study. It has high reported validity, yields high response rates, is formatted for quick self-completion, and avoids contamination by physical illness^{218,252}. It also has a number of additional advantages over rival measures such as the Hospital Anxiety and Depression Scale (HAD). It has been extensively validated^{218,252}, is the most widely used psychiatric morbidity screening

test available²⁵⁷, has been used successfully with young adults^{258 218,254} (including a study of help-seeking²⁷), and can be extended to explore suicidal thoughts (GHQ-28). It also attempts to allow for variations in individual's self-reporting thresholds by building relativity into the response categories, and is reported to detect a full range of cases. The GHQ is available in versions of differing length but the 12-item version was considered most appropriate for a short postal questionnaire. The GHQ-12 has a reported sensitivity of 89% (95%CI 85% to 92%) and specificity of 80% (95%CI 77% to 83%) with no indication of a significant effect on validity with gender, age or class of respondent.

The 12-item General Health Questionnaire (GHQ-12)

The GHQ-12 screens for minor neurotic disorders such as depressive disorder, anxiety and panic disorder. These, therefore, are the types of morbidity included in the general category 'mental distress' referred to throughout this thesis. It does not make clinical diagnoses or distinguish types of disorder, but is a probabilistic 'first-stage' measure that identifies *probable* cases of disorder that can then be verified with a second stage instrument. Full details of the GHQ's development, design, administration and validity are provided in the User's Guide²¹⁸. A brief summary is provided here outlining how the GHQ was used in this study.

The GHQ focuses on 'breaks in normal function' rather than long-term disorder. The 12 items measure recent inability to carry out normal functions and appearance of a range of symptoms such as concentration problems, sleep disturbance and feelings of depression. Each item asks respondents to rate how much they have recently experienced the specified symptom compared to usual on a four-point scale ranging from 'less than usual' to 'much more than usual'. The conventional GHQ scoring method was adopted in this study²¹⁸. This scores all items bimodally, the two response categories indicating negative deviation from usual scoring '1' and the remaining two categories scoring '0'. This method eliminates the difficulty of bias introduced by middle versus end users but counts the number but not intensity of symptoms and therefore compromises some ability to detect severity. A GHQ score (range 0 to 12) gives an assessment of an individual's position along the continuum from normality to illness.

The GHQ focuses on psychiatric disorder as a category. It taps into the distinction between likely cases and non-cases and can estimate the prevalence of disorder by applying a threshold score or cutpoint and defining all those scoring above this as cases. However, as GHQ score also gives a proxy measure of the individual's position on a

dimension of psychiatric illness it is also meaningful to use GHQ score as a continuous variable to compare the *amount* of disturbance or gain a grasp of severity. GHQ score was used in both ways in this study.

Due to its focus on recently occurring or new symptoms, the GHQ can be sensitive to transient disturbances that do not persist long enough for formal classification as disorder and/or remit spontaneously without treatment. Non-cases or mild disturbances (symptomatic but not disordered) can therefore be misclassified as cases, which could over-estimate the problem of non-help-seeking. To be used meaningfully, the concept of a 'non-help-seeker' must require an individual to not only have persisting symptoms, but also to have endured these for a length of time without seeking help. The threshold score providing optimal trade off between sensitivity and specificity has varied across studies for reasons still poorly understood^{218 259}. A lower threshold protects sensitivity while a higher threshold improves specificity. It is most meaningful to study help-seeking where the screening procedure maximises the probability of identifying individuals for whom help-seeking may be appropriate and beneficial. In this survey, the threshold for caseness effectively defined 'need for help' as well as caseness. A low cutpoint with a higher false positive rate could exaggerate the problem of hidden/untreated morbidity. The higher of the most conventional thresholds²¹⁸ was therefore adopted and those scoring 4 or more out of 12 were considered to be cases.

It is also acknowledged that the GHQ may miss chronic cases of disorder because of its focus on change rather than the absolute level of a problem²¹⁸. The response scale detects cases by measuring recent deviation from a 'usual' state, which is assumed to be a state of normality. However, for chronic cases, 'usual' may be a state of disorder and chronic cases may respond 'same as usual' when asked about long standing symptoms to indicate no change in their condition. This would result in no score and therefore the classification 'non-case'. This could be problematic if the help-seeking of chronic cases differs from that of other cases in prevalence or type. Goldberg and Williams²¹⁸ indicate that this problem is less great than it might appear since many chronic cases interpret 'usual' as meaning their symptom-free self. They also present two potential solutions to this difficulty:

1. To add two supplementary questions:
 - a. Are you taking any medicines or tablets for your nerves?
 - b. Do you think you have a nervous illness?

2. To use an alternative scoring method proposed by Goodchild and Duncan-Jones (1985)²⁶⁰ to improve detection of chronicity – the Corrected GHQ (CGHQ).

Evidence for the CGHQ is not certain²¹⁸ and it has several conceptual problems. CGHQ scoring was not therefore used in this study. Instead, variants of the supplementary questions (above) were included in the questionnaire (qu. 9 & 10). Since the difficulty of the GHQ in relation to chronicity centres around the meaning 'usual' and the possibility that this may be different for chronic cases compared to other responders, an additional question was also devised for inclusion in the questionnaire (qu.8). This asked responders to define what they considered to be their 'usual' state of psychological health and therefore the comparative benchmark they had used when responding to the GHQ. The data from these questions were used to assess likely misclassification of chronic cases and in qualitative sampling (below).

Suicidal thoughts

Four questions from the GHQ-28²³⁰ 'severe depression' sub-scale were added to the questionnaire to measure recent suicidal thoughts. These measure increasing levels of suicidal thought - 'feeling that life is entirely hopeless', 'feeling life isn't worth living', 'wishing oneself dead and away from it all', and 'finding the idea of taking your own life kept coming into your head'. Respondents who scored on any of the last three items were regarded as experiencing suicidal thoughts. The first suicide item, feeling life is hopeless, was not alone deemed indicative of actual suicidal thought.

Medicine taking and self-rated mental ill health

Questions added to measure chronicity were also a means of exploring self-medication since they were worded to allow reporting of herbal/ folk remedies and drug-taking as well as prescribed medication. Further, they were another measure of formal help-seeking that could identify individuals involved in long term programmes of care who happened not to have seen a health professional in the previous four weeks which was the period over which recent help-seeking was assessed (below). Asking respondents whether they thought they were currently suffering from psychological or emotional problems was a means of assessing recognition of mental ill health. This could be compared to GHQ score and data about suicidal thoughts and the relationship between recognition and help-seeking explored. Questions about past problems and medicine use could identify 'past cases' for interview.

Help-seeking

Section three of the questionnaire - 'About getting help' - collected the main outcome data for this study and provided information for sampling interviewees who had adopted varying help-seeking behaviours. Past and recent help-seeking for 'psychological or emotional problems' was covered and respondents were provided with a broad definition of help-seeking which prompted them to consider help-seeking from informal as well as formal sources and to include advice as well as *help-seeking*. Past help-seeking was defined as *ever* seeking help and recent help-seeking as seeking help in the last four weeks. This period of four weeks was chosen to coincide with the period covered by the GHQ so that help-seeking behaviour could be matched with caseness. The questions for past and recent help-seeking mirrored each other.

Firstly, respondents were asked if they had sought *any* help-seeking for mental distress to gain overall estimates of past and recent help-seeking. Respondents could answer 'yes' or 'no' but two response categories were included for 'no' to differentiate those who had not sought help and perceived no need for help from those who had not sought help but considered that they should have done. For recent help-seeking these data too could be matched with GHQ score to explore perceptions of need amongst cases. Respondents who reported help-seeking were then required to answer two further questions:

- *From whom they had sought help*: Respondents were asked to indicate whether they had sought help from a range of sources including healthcare professionals (GP, counsellor, psychiatrists), the lay group (friends, family, teachers, employers), and the voluntary sector (self-help groups, voluntary services, Samaritans), and to specify any other help sources they had contacted.
- *Why they had sought help*: Respondents were presented with the open-ended question 'why did you decide to seek help at this time?'.

A third question (qu.15) was also included to explore the issue of *non-help-seeking* asking respondents whether they had ever *not* sought help for psychological or emotional problems when they either thought they should or felt they would like to. Those who had were asked the reason for their non-help-seeking to collect preliminary data about barriers to help-seeking from a large-scale representative sample.

Exploring illness behaviour

The fifth section of the questionnaire contained a vignette about a mentally distressed young adult developed in the piloting phase (above). Open-ended questions were posed to explore lay diagnosis and illness behaviour recommendations. This vignette, like responses to the other open-ended questions in the questionnaire, were scanned when purposively sampling for qualitative interviews (below) and for background information prior to interviewing, but otherwise have been treated as a separate dataset and were not systematically analysed for this thesis.

Data management and analysis

Returned questionnaires were logged in order to monitor the number of responders, refusers and undelivered questionnaires, and to facilitate the mailing of reminders. An Access database was constructed to enter and store data. This involved constructing data entry screens which minimised entry errors by recognising most invalid codes. When data entry was complete, the dataset was copied from Access to Stata (version 7) software package²⁶¹ for cleaning and analysis.

Data preparation

Prior to statistical analysis, the survey data were cleaned and coded. The data were checked for accuracy by performing range checks on each variable and searching for invalid codes and impossible or unlikely values. Data consistency was then examined by cross tabulating related variables and ensuring combinations were plausible. Finally, the data were checked for completeness by identifying missing values. Outliers, inconsistencies and missing data were investigated by referring to the original questionnaire and corrections were made accordingly.

Most questions had pre-coded response categories. Continuous variables such as GHQ score and social support scores were calculated afterwards, though the scoring system for these were predetermined by the standard methods^{218,241}. There was also minimal post-coding of some 'other' response categories to group like responses and of open-ended questions. Medications were coded using the British National Formulary 41 (BNF)²⁶² and social class using the ONS classification of occupations 2000²⁴⁵.

To facilitate analysis, some additional variables were derived from the existing data: Townsend score from postcode data available for all those sampled from AHA; GHQ

caseness from GHQ score (those scoring 4 or more); and suicide caseness from responses to the GHQ-28 subscale items. For some analyses, in particular logistic regression analysis, some data were summarised, though in all cases data were first explored in their original form to ensure that this would not obscure any differences. Continuous variables (age, Townsend score, GHQ score and social support scores) were categorised into groups of equal width. Some multi-level variables such as parental social class were grouped into broader categories so that the important differences in each variable could be examined in models with less parameters and so more power to detect differences. Categories were only combined with others where this grouping was consistent with their meaning. Any past and current help-seeking were mainly treated as a binary variable by merging the categories 'no – I have not needed to' and 'no, but I think perhaps I should have done' since both categories represented those who had not sought help.

Data obtained about the respondent's residency and main occupation were also summarised for regression analysis in order to produce a hierarchy of responses which reflected major differences potentially relevant to the experience of mental disorder and processes of seeking help. For instance, those who had in some way established relationships and living arrangements independent from or in addition to the family unit were separated from those who had not. In the case of occupation, a hierarchy was created based on engagement activity outside and inside the home.

Analysis strategy

Data analysis was carried out in a series of progressive stages. It began by obtaining summary statistics to describe the main characteristics of respondents. Bivariate analysis using chi-squared and t-tests was then used to compare the characteristics of early and late respondents in an attempt to explore the possible characteristics of non-responders. The next phase of analysis used the same methods to calculate the prevalence of GHQ caseness amongst the sample and to explore the patterning of this by comparing the characteristics of cases and non-cases. Additional variables such as medication taking and usual psychological health were cross-tabulated with GHQ score in an attempt to assess the possibility that there were chronic cases that had not been identified by GHQ screening (see above).

The main analysis then focussed on help-seeking. After considering the total prevalence of help-seeking amongst all responders, remaining analysis focussed on three subgroups: 1) GHQ cases, 2) suicide cases (those reporting any recent suicidal thoughts – see above), 3) respondents who reported recent thoughts about taking their own life. For each group, analyses explored the prevalence of help-seeking and factors associated with help-seeking. Where considering help-seeking amongst GHQ cases, gender differences were identified and these were explored further by analysing males and females separately.

Descriptive statistics and bivariate analysis were used to calculate the prevalence of help-seeking amongst each group and the patterns associated with help-seeking behaviour. Chi-square and t-tests were used to examine differences in the characteristics of help-seekers and non-help-seekers and p-values are presented. Patterns of association were then considered further using logistic regression techniques to investigate associations of help-seeking with socio-demographic characteristics, morbidity factors and the level of social support reported by the individual. In each analysis, the outcome measure was whether or not help had been sought and analysis was carried out for three types of help-seeking: 1) from any source, 2) from a GP, and 3) from friends and/or family. The effects of factors on help-seeking were first considered unadjusted and then in multivariable models controlling for GHQ score (the factor most strongly related to help-seeking) by fitting this as a continuous term to identify factors associated with help-seeking independent of case severity. Separate multivariable models were also used for males and females and all factors found to be associated with help-seeking ($p < 0.10$) entered together in a final multivariable model controlling for the effects of all variables on each other. Results are presented as odds ratios with 95% confidence intervals and p-values. P-values were regarded as a measure of the strength of evidence for or against the null hypotheses rather than as a means of categorically defining significance and non-significance according to an arbitrary threshold level of 5%²⁶³.

Qualitative interviewing

A qualitative approach has been defined as being concerned with: “the development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences, and views of

all participants”²⁶⁴. This is achieved through “intense and/or prolonged contact with the field”²²⁵ and the words and/or observable behaviour of those under study.

Qualitative methods have strong roots in the social sciences²⁶⁵ and in recent years, have gained higher profile and acceptability within health services research²⁶⁶, including the BMJ which has published papers making a strong case for the relevance and usefulness of qualitative methods in this field^{267,268}. Qualitative research is attributed with the ability to explore areas not amenable by other (quantitative) approaches such as health beliefs and understandings, practitioners’ and patients’ attitudes, and the meanings of illness and treatment in the lives of patients. Moreover, a qualitative approach can use such knowledge to provide explanation, rich textual description, and to make sense of behaviour, including the gap between theory/evidence and practice and that which is seemingly irrational, such as patient non-compliance or the failure to act upon health education²⁶⁶⁻²⁶⁹. Qualitative research is defined further by its key characteristics^{225,269} – including naturalism, holism, interpretation, process, interaction and insider’s perspective (Table 4.3). A qualitative approach was therefore well suited to this study, which aimed to understand not only the patterning of help-seeking but also the factors shaping this.

Table 4.3: Key characteristics of a qualitative approach

<i>Naturalism</i> – the attempt to understand behaviour in its everyday context, in real life settings and often in real time, in recognition of the fact that human beliefs and behaviour are rarely reconstructed satisfactorily in artificial experimental conditions.
<i>Holism</i> – focus on gaining an encompassing understanding of the issue/ situation at hand including its context, contradictions and hidden aspects.
<i>Interpretation</i> – the investigation of how people make sense of and attribute subjective meanings to ‘objective’ reality, in order to understand how these shape their action.
<i>Process</i> – the ability to research how things happen as well as what happens and to examine beliefs and behaviour as the by-products and outcomes of evolving social processes.
<i>Interaction</i> – exploration of how beliefs and meanings are constructed through negotiation and interaction with others.
<i>Insider’s perspective</i> – the attempt to obtain the voice and experience of those being studied and an empathetic understanding from their perspective.

Objectives and design

The main objectives of the qualitative research were:

- To explore young adults' understandings of mental distress and the appropriateness of help-seeking.
- To examine the reasons why interviewees had or had not sought help and current intentions (where appropriate).
- To examine specific issues relating to help-seeking for mental disorder amongst young adults.
- To investigate interviewees' perceptions of help and available help-sources.

Theory and approach

The term qualitative research disguises a diversity of theoretical approaches and methods^{225,270}. The qualitative research for this thesis was conducted within the interpretive tradition and drew upon components of grounded theory as a methodological strategy to guide the empirical approach and theory development. These approaches guided both the collection and interpretation of data in order to ensure that the research was explanatory rather than merely a process of accumulating and describing narratives in mechanistic fashion without attempting to 'make sense' of these and how they come to be²⁶⁶. The research was also pragmatic aiming to deriving robust qualitative understanding of a practical problem, rather than to engage in theoretical or polemical debate.

Interpretivism

The interpretive approach is attributed to Husserl (1859-1938) and received particular development by sociologists in the 1960's and 1970's. Interpretivism emerged from a critique of positivist and quantitative approaches to examining human behaviour on the basis that these are divorced from everyday life²⁷¹. It is a theory of social action and of agency²⁷² that aims to understand "the complex world of lived experience from the point of view of those who live in it"²⁷³. It does this by exploring, without the constraints imposed by quantitative methods, how people interpret, assess and make sense of their experiences and the world around them by attaching meanings (norms, values and beliefs) to objects and events²⁷¹.

By gaining knowledge of how people assess the world, interpretivism aims to account for how people choose courses of action²⁷². Interpretivists emphasise that people, unlike the subject matter of natural science, have consciousness and that this mediates their response to stimuli. Social action and human behaviour are not explicable by cause and effect relationships but are evolving, purposeful and intentional responses based on actors' interpretations and application of meaning to events. It is these meanings that provide logic to what people do and seemingly irrational behaviour can make sense when meanings are uncovered. Meanings are established, attributed and negotiated through social interaction and interplay with the social and cultural environment as new experiences are encountered²⁶⁶. Meanings are therefore changeable, context-bound and multiple. Interpretivism then, essentially entails the study of meanings, motives and context.

Differing strands can be identified within the interpretivist tradition, phenomenology being a major school and other 'off shoots' including symbolic interactionism, ethnomethodology, and grounded theory^{271,274}. A notable application of an interpretive perspective to the study of illness behaviour is that of Dingwall (1976)⁸⁶ who critiqued previous approaches for taking 'objective' medical definitions of disease as their starting point and attempting to account in behavioural terms for individuals' 'irrational' failure to use formal services. He proposed a shift in focus to examining how people come to feel ill and what they do about this. Dingwall attempted to account for illness behaviour as a form of social action dictated by the social meanings assigned to symptoms as the result of processes of interpretation. This led him to focus on lay concepts of illness – that is, health beliefs and theories that allow actors to analyse situations – and to view illness as a social construction rather than purely a biological entity. He argued:

There can be no such thing as 'essential illnesses'; rather there are sets of socially organised events organised by members of a collectivity into categories of experience to which the identification 'illness' is accorded...if we want to explain how and why people relate to their bodies in certain ways and embark on particular courses of action, we need to examine the relation between biological events and the way in which they are construed by members of a collectivity in light of the theories about health and illness available to them. A prime task of the medical sociologist is then, the study of how lay persons theorise about the human body (pg26-7)⁸⁶

Dingwall's focus then was on how certain events, or events in certain contexts become defined by lay people as illness on the basis of their theories about the body, "everyday knowledge about wellness" and the "typical and atypical deviations that may arise". He

argued that without analysing such interpretive processes and the ascription of meaning, the action (illness behaviour) following from this cannot be fully understood since he also argued that such theories are the basis for making and justifying all illness behaviour decisions and generate action ranging from dismissal through self-medication to formal help-seeking and choice of help-source.

According to Dingwall, help-seeking thus depends upon the interpretation of symptoms as meaning illness (or potential illness) and therefore as relevant conditions for social action, which may not occur until multiple alternative interpretations are applied and exhausted. Dingwall elaborated this to argue that 'illness' definitions are employed not only by the sufferer to make sense of their experience, but that theories are transmitted, negotiated, validated and sometimes imposed through social interaction. He proceeded to state that health is a moral category to which illness poses a threat and that the classification of experience is motivated by such factors. Dingwall's approach has clear relevance for this thesis as an example of how and what an interpretivist perspective can contribute to the study of help-seeking.

An interpretivist perspective requires a particular approach to research and knowledge generation. The quest to access actors' meanings and motives requires an in-depth approach that can delve at the level of individual's subjectivity. Knowledge should be acquired by *verstehen* – that is, empathetic understanding through taking the perspective of the person or situation being researched in order to understand the meanings that they give to their actions²⁷⁵. This requires immersion so to 'feel one's way inside the experience of the actor' and to 'catch the process of interpretation' through which action is constructed²⁷⁶. Such understanding is also explanatory because it accesses motive. Recognition that meanings are negotiated and fluid adaptations to situations and that social interaction is in constant flux calls for a similarly flexible and holistic empirical approach that can respect such complexity rather than a static approach that attempts to uncover fixed rules²⁷⁴. Interpretivist research also requires 'bracketing' or setting aside our taken for granted knowledge and judgements about the world in order to trace the development of these²⁷⁷. Grounded theory introduced by Glaser and Strauss in 1967²⁷⁸ and later developed and modified^{279,280} provides an approach towards achieving this and is derived from the interpretative tradition and the aim of understanding the 'life worlds' of respondents²⁷⁴.

Grounded theory

Grounded theory is described as providing a bridge between the empirical and theoretical^{281,282} and is defined by Glaser and Strauss as “the discovery of theory from data systematically obtained from social research”²⁷⁸. It provides guidelines and strategies for qualitative data collection and analysis in the form of a series of inductive steps²⁸¹. These enable researchers to progress from a position of general inquiry at the start of a research project to the discovery of social processes and the generation of theory and concepts that explain the phenomenon under study and can improve the reliability²⁸² and credibility of the analysis by providing a systematic, data driven method of inquiry.

The essential principle of grounded theory is that theory should be generated inductively through systematic and detailed data collection that allows that which is theoretically relevant to emerge. In short, interpretations are discovered and ‘borne out of the materials’²⁷⁸. This was intended to oppose ‘verificatory sociology’ where theory is assumed *a priori* and the research process revolves solely around an attempt to test this²⁷⁸, and worse, the opportunistic use of existing theory to explain findings. Glaser and Strauss argue that an inductive approach ensures a theory that ‘fits and works’ - is specific, immediately applicable, indicated by the data and able to explain the behaviour being studied.

While variations in grounded theory have emerged with its development²⁸³, a number of common data collection and handling procedures are recommended²⁸¹. Underlying each of these is Glaser and Strauss’ main strategy - that of comparative analysis: “the systematic choice and study of several comparison groups”²⁷⁸.

Simultaneous data collection, coding and analysis

Grounded theory requires a *process* of research where data collection and analysis “should blur and intertwine continually, from the beginning of an investigation to its end”²⁷⁸ and are iterative. A process is described whereby the researcher initially enters the field with broad areas of interest. These are explored in a preliminary round of data collection. Analysis of this data reveals further, alternative or more pertinent issues and questions and also draws attention to gaps in knowledge. These are then explored in subsequent phases of data collection. This process continues through several iterations creating a detailed, full and refined understanding highly responsive to, guided and

‘grounded’ by the reality that is being investigated. Hunches and analytical themes are also verified during this process ensuring strong congruence between raw data and the derived interpretations. The research process is therefore characterised by flexibility to ‘listen’ to the data²⁷⁸.

Theoretical sampling

Qualitative sampling is non-probabilistic and focused on small samples of people ‘nested in context’ and studied in-depth²²⁵. It aims to derive understanding rather than statistical generalisability and does so by accessing those with relevant characteristics or experiences who can be viewed as sources of knowledge²⁸⁴. In the context of a grounded approach, Glaser and Strauss describe sampling as central to the process of refinement (above)²⁷⁸. The act of identifying themes and gaps and generating concepts requires the researcher to also consider where or from whom further data must be collected in order to explore and refine these further. Sampling must respond to these requirements and cannot be pre-decided. It is therefore flexible and theoretically purposeful, decided deliberately in response to the data rather than the researcher’s presuppositions. Central to this is the act of selecting diverse comparison groups for analysis to look for variability and similarity (below) and to expand the generality of the theory.

Constant comparison method of data analysis

‘Constant comparison’ is an analytical procedure for the systematic development of theory and understanding and is carried out in the context of theoretical sampling and simultaneous data collection. Glaser and Strauss say that this approach allows for the generation of a theory that is “integrated, consistent, plausible and close to the data”²⁷⁸, and facilitates the necessary creativity for ‘theoretical sensitivity’ in a disciplined manner. Constant comparison involves three stages:

1. All data are coded according to emergent themes and into categories. During this process, there should be a constant comparison of new data (within and across respondents) with data already assigned the same coding in order to derive a complete picture of the code and its properties. During this process, questions and theoretical thoughts will emerge which should be recorded as a memo and used to direct further data collection (above) and the difference between ‘in vivo’ coding (the direct words or categories of the respondents) and codes

conceptually derived by the analyst as a means of explanation should become apparent.

2. As data collection and analysis develop, constant comparison shifts from comparing incidents with the same coding to an attempt to compare emerging incidents with more conceptual categories to test for their fit within these frameworks and, in the process, to refine these emerging underlying concepts and theories.
3. Further comparison serves to delimit the underlying characteristics or generalities of each category or concept by seeking saturation. These categories form the basis of a theory.

Constant comparison therefore offers a means of systematically interpreting and organising rich raw data to arrive at major themes and a theory to account for these. Robustness and validity of interpretation is achieved by sampling for maximum diversity (above). Important to this process is the search for and selection of 'deviant' or 'negative' cases (exceptions to emerging patterns) that can illuminate areas of difference and contradiction and provide disconfirming evidence ²⁸². This and the attempt to explain such difference is essential to ensuring complete grasp of the properties underlying processes. These can be theoretically sampled or discovered within the data set.

Method of data collection

In-depth semi-structured interviews were selected as the most appropriate means of data collection for this study. Semi-structured interviews are 'directed conversations'²⁸¹ consisting of open-ended questions and a flexible guide of topics to be explored. Interviewees are encouraged to talk at length and in their own terms allowing them to express their own thoughts with a minimum of direction or prompting from the researcher. Topics are covered as they occur 'naturally' in the 'conversation' rather than according to a pre-specified order. Equally, respondents are able to identify matters of importance relating to the research question that are not included on the topic guide, which the researcher can probe for further detail²⁸⁵. Interviews therefore provide a means of directly exploring the points of view and subjective worlds of research subjects²⁸¹ and of accessing the 'meanings people attribute to their experiences and social worlds'²⁸⁶. In-depth interviewing also fits well with the methods of grounded theory

because it combines the necessary flexibility to allow themes to emerge naturally, with sufficient interviewer control to direct conversation towards conceptual gaps or issues that require further refinement²⁸¹. Further, individual interviewing is an appropriate technique for addressing sensitive subject matter²²⁸ as in this research.

The second component of the study therefore involved in-depth qualitative interviews with a sample of survey respondents whose questionnaire responses suggested they were either current or past 'cases' with mental distress. Personal narrative of past and/or current distress replaced the vignette used in pilot interviews and a detailed account was obtained from each interviewee of their experiences of mental distress, their illness behaviour in response to this, and the rationales and other factors shaping this behaviour.

Sampling and recruitment

In accordance with principles of grounded theory, sampling in this study had the objectives of:

- 1) interviewing individuals with a range of characteristics and experiences of mental distress to refine understandings, increase quality²⁸⁷ and improve the transferability of the findings by noting both the variety of experience and also patterns across cases²⁸⁸;
- 2) obtaining data from those who had sought help as well as those who had not to facilitate comparative analysis;
- 3) following emergent themes and theoretical leads in the data.

Maximum variation sampling and theoretical sampling (above) were used to achieve these objectives. Potential interviewees were identified by responses to the questionnaire. Sampling was flexible and progressive, evolving with each wave of data collection to explore new leads and secure an interview with a representative from a range of 'groups' of respondents, including difficult to recruit groups. There were five main waves of sampling relating to each batch of survey administration. In the first wave, sampling took a broad approach. The strategies in subsequent waves were more targeted and were adjusted to fill gaps in recruitment, follow leads from preliminary analysis of data, and to search for deviant cases.

There were two potential types of informant, each offering differing data:

- 1) 'Current cases' identified by a score of 4 or more on the GHQ-12, or chronic cases indicated by a poor self-rating 'usual' psychological health and current medication use (above). These cases allowed exploration of mental distress and help-seeking behaviour as they occurred and in context.
- 2) Past cases identified by past formal help-seeking or medication use for psychological/emotional problems, or reporting of past problems of this nature. These allowed exploration of a complete illness behaviour trajectory and its outcomes.

Amongst current and past cases, there were key variables that the literature indicated might influence illness behaviour and which were therefore of theoretical interest - gender, age, socio-economic status, level of distress (GHQ score), chronicity, and the perception of having psychological/emotional problems. Other key variables such as help-seeking status (help-seeker or non-help-seeker), and type of help sought (GP, friends and family and other agencies) provided differing 'events' or 'processes'²²⁵ for sampling.

Maximum variation sampling ensured that individuals were recruited to give a varied and balanced sample. This required disproportionately sampling from groups of individuals who were more likely to refuse interview until respondents from these groups were obtained. These were: younger females (aged 16-19 years), older males (aged 20-24yrs), female non-help-seekers and male help-seekers. It became apparent that the distinction between past and current cases and help-seekers and non-help-seekers was not as simple as presupposed. Many 'current cases' also described past episodes and interviewees with long trajectories or multiple experiences of distress did not have a single help-seeking status as classified in the survey but recounted complex trajectories of illness behaviour including episodes of both help-seeking and non-help-seeking. For clarity, later sampling attempted to unravel some of this complexity by targeting current cases with no indicators of chronicity or past episodes and vice versa and help-seekers whose questionnaire implied their pathway to care had been direct. An early tendency towards the recruitment of chronic/extreme cases was also tackled by using indicators such as GHQ score, suicidal thoughts and medicine-taking to distinguish potentially less severe cases until the sample was more varied, though this approach also increased the possibility of recruiting 'non-cases' misclassified by the GHQ (above).

Responses to open-ended questionnaire items were also used, particularly in later sampling, to decide which individuals to approach. These could indicate potential deviant cases or new themes for exploration, such as the use of alternative coping strategies including DSH and self-medication, or additional reasons for non-help-seeking. They could also indicate the length of episode.

Recruitment

Supervisors with a clinical background (DG, DS) reviewed potential interviewees' questionnaires before recruitment letters were mailed to improve interviewer safety, though none were excluded. Sampled individuals were sent a recruitment letter (with reply slip) inviting them to interview (appendix 9) and accompanying study information sheet (appendix 10). Those agreeing to participate were asked to supply contact details. They were then contacted by telephone to arrange a convenient time and location for interview. Refusers were invited to explain the reasons why they did not want to take part.

The interview

In-depth interviews were carried out with 23 young adults. Interviews were conducted in a private room at the University (n=18) or at the respondent's home (n=5) according to the interviewee's preference and lasted between 1 and 2 hours. A verbal explanation of the study and interview process was also given before proceeding and interviewees were given the opportunity to ask questions. This task was also used as an opportunity to set interviewees at ease and to establish some degree of rapport through general conversation. Interviewees were then asked to sign a consent form (appendix 3) and if they would permit tape-recording of the interview. All agreed to this. A flexible topic guide was used as an interview schedule (below). Prompting was used only where necessary, to ensure all areas were explored and in sufficient depth and to curtail irrelevant digression from the research question.

Interviews were conducted in five phases relating to each batch of questionnaire mailings (Table 4.2). A preliminary analysis of the data was conducted after each phase while the next batch of questionnaires was administered. This fulfilled the interweaving of data collection and analysis advocated by grounded theory (above). Emergent themes were explored in the next interviews accordingly. This 'batch' approach also meant that

respondents could be interviewed soon after returning their questionnaire while their self-reported mental state (GHQ-12 score) remained relevant (above). Of the 23 interviewees in this study, 11 (48%) were interviewed within a month of completing their questionnaire. The mean delay was 36 days (range 17 days – 80 days). Interviewee factors increasing delay were promptness of response to recruitment letter, contactability, and postponement of interviews dates (n=2). The need to re-sample following failure to recruit individuals with particular characteristics also added to the delay in some cases.

Interview topic guide

All interviews began with open-ended questions about understandings of health, illness and mental distress, as a general introduction before exploring personal areas. A topic guide (Appendix 11) was then used loosely without imposing order on the discussion of areas. Themes were allowed to emerge naturally in conversation and were ticked off as they were discussed to keep a record of what had been covered. Towards the end of the interview, or at gaps in the conversation, interviewees were asked about areas that had not been covered. Particular questions or thoughts occurring while the respondent was speaking were noted on the guide and followed-up at an appropriate interval.

The interview topic guide evolved throughout data collection, being revised regularly to incorporate findings and leads from earlier interviews and thereby facilitate a grounded approach. In total there were five main iterations of the guide.

Assessing psychiatric morbidity

It was possible that some individuals could have been inappropriately recruited for interview if they were misclassified as 'cases' due to the GHQ's sensitivity to transient disturbances (above). In order to assess this possibility and whether it was reasonable to believe that those interviewed may *need* to seek help, levels of mental distress were examined in more depth during interviews by asking interviewees to complete the GHQ-12 again and administering the Clinical Interview Schedule (revised version) (CIS-R)³². The GHQ was also used as an 'icebreaker' and prompt for discussion. The importance of this issue was not immediately apparent and the GHQ was not introduced formally into the interview schedule until the fifth interview, and the CIS-R schedule until the sixth.

The Clinical Interview Schedule (revised) – CIS-R

The CIS-R³² provides a standardised assessment of minor neurotic disorder by replacing clinical judgement with rules. It aims to replicate a psychiatric assessment and so could provide a more detailed and accurate assessment of interviewees' caseness than the GHQ. The schedule has fourteen sections, each asking about the experience of a particular symptom and its severity and frequency in the past week. Those covered include: depression and depressive ideas, anxiety, phobias, and panic. A score is obtained for each symptom and these are combined to produce a CIS-R score (range 0-57) denoting severity and giving an indication of the individual's position along a continuum of disorder. A threshold (usually 12^{31 33 32}) can be applied to indicate caseness.

The CIS-R was used in two UK psychiatric morbidity surveys^{31 33}. Its cultural applicability and potential to be used with young adults has therefore been demonstrated. Further, the CIS-R was designed for use by lay researchers, which was a requirement in this study. Lewis et al report that lay interviewers show similar reliability and precision in assessment of caseness as psychiatrists. This is not true of rival measures such as the Diagnostic Interview Schedule (DIS) which are also less easily administered^{252 32}. The CIS-R also shows good reliability and a close relationship with psychiatrists' independent assessments of severity, thereby suggesting validity³².

Ethical considerations

A protocol was devised prior to interviewing for responding to interviewees disclosing significant distress or suicidal thoughts who were not receiving treatment or other help. Booklets were purchased from 'Depression Alliance' and a list of local help services was prepared (appendix 12) to give to respondents. A standard letter was also composed which was addressed to the interviewee's GP and could be offered to interviewees whose CIS-R responses suggested this was appropriate. The letter gave details of the study and stated that the respondent appeared to be experiencing symptoms of mental distress (Appendix 13) and could be handed by the interviewee to their GP at their own discretion should they decide to consult following the interview. Should cases of particular concern arise, (e.g. suicidal risk) the protocol stated that attempts would be made to encourage help-seeking or to seek permission from the interviewee to make contact with their GP or other help agencies on their behalf. Clinical back-up (DS) was

also available for such cases and if a tension arose between confidentiality and the duty of care. During the course of the interviews, GP letters were issued to several respondents.

Data management and analysis

A thematic analysis was conducted drawing on the method of constant comparison (above)²⁷⁸ and with detailed reference to qualitative analysis text-books, including those elaborating upon grounded theory^{279,280 225}. The computer software Atlas-ti²⁸⁹ – a programme designed for use in qualitative data analysis and based in part on grounded theory methodology was used to assist in this process. Atlas-ti allows the storage, labelling, manipulation, easy retrieval and display of data, but cannot *perform* analyses²⁹⁰.

As recommended by grounded theory, the process of analysis was ongoing and interwoven with data collection. As already described, interviews were conducted in five batches between survey administration. Within batches of interviews, any particular reflections made after each interview were noted and carried forward to the next interview and between batches more formal preliminary analysis was conducted. This allowed the formulation of hypotheses and questions to be explored in later interviews and revealed gaps ensuring that data collection was improved in these areas. Analysis involved a series of stages.

Transcription

Interviews were tape-recorded and then transcribed verbatim so that analysis would be based on accurate, public and highly detailed representations of the social interaction²⁹¹. All tapes and transcripts were anonymised for confidentiality purposes and stored securely. A clerical assistant initially prepared transcripts according to standardised format and instructions for indicating pauses and their length, overlapping speech, intonation and emphases, and vocal expression in order to secure maximum inclusiveness of data and therefore improve reliability of interpretation²⁹¹. I then checked and corrected these transcripts by re-playing tapes and comparing these with the prepared transcript. On occasion, I was able to add details of actions accompanying talk. Such checking also aided familiarisation with the data. Corrected transcripts were imported into Atlas-ti.

Contact sheets and field notes

More detailed scrutiny of the data was then achieved by completing a contact sheet²²⁵ for each interviewee on the basis of a preliminary review of the transcript and field notes from the encounter. This entailed logging the social and morbidity characteristics of the respondent to keep a record for further sampling, writing a short descriptive summary of the illness episode and behaviour, and most importantly, served to create a summary of the main theoretical and conceptual issues, themes and questions arising from each interview thereby prompting detailed reflection and providing orientation for subsequent interviews. Any pertinent fieldwork observations were also recorded on this sheet. Contact summaries had the further benefits of suggesting conceptual codes for analysis (below), allowing early comparison across respondents and, in later analysis, served as a contextual reminder of respondents' complete narratives as these became deconstructed by thematic analysis. An example contact sheet is given in Appendix 14.

Coding

Coding was a central part of analysis. Codes are 'labels for assigning units of meaning'²²⁵ to data and the process of coding involves 'dissecting' the data in a meaningful way so that the essential units and relationships between these can be identified, explored, described and conceptualised^{225,280}. Strauss and Corbin (1990)²⁸⁰ describe coding as the 'central process by which theories are built from data'. They suggest differing levels of coding.

Open coding

Open coding involved scrutinising transcripts in great detail for themes and concepts and then assigning codes to segments of data according to the meanings they contained. Initially codes were highly descriptive and were derived directly from the data - where possible using respondents' own terminology as labels. Particular attention was given to context when coding to ensure meanings were not misconstrued. When the first few transcripts had been coded, a 'list of codes'²²⁵ was composed in order to display existing codes and note those that were recurring. This made it possible to begin moving beyond a mere describing of data to a more conceptual labelling so that a vast number of codes were reduced into a more meaningful number so that generalities could be drawn and segments of text with the same code compared within and across transcripts for content. This coding list was continually refined as further data were collected and transcripts

coded revealing new themes, or sub-themes within broader codes. Matrices of the occurrence and co-existence of themes were constructed in order to explore patterns in the data and according to respondent characteristics such as gender.

Axial coding

To move beyond merely identifying recurring themes, progression was made to 'second level' coding. Although Strass and Corbin describe 'open' and 'axial' coding as separate phases, in this research the two merged – axial coding occurring as a natural progression. The coding list was developed into a coding frame where codes (concepts) referring to similar events were grouped to form categories. These categories were assigned more abstract names to reflect their analytical nature and the higher level of interpretation involved. Once viewed as categories, the codes belonging to each could be explored with a view to establishing the properties and dimensions of each category. Codes could also be considered according to their 'type'²²⁵, for instance, if they represented a process, an outcome, or a motive for behaviour. This meant that hypothesised connections could be made between aspects of a category.

The coding frame and the links made between codes and subcodes were adjusted with each batch of interviews as understanding was refined.

Descriptive accounts and conceptual framework

Central to the process of coding – particularly axial coding - was the process of constantly comparing segments of data to identify similarities, differences and interconnections within and across themes. This was achieved by preparing descriptive accounts. These involved extracts of data sharing the same code being retrieved from within and across respondents and detailed summaries of the content of each code being composed. This made it possible to double check that data assigned the same labels did relate to the same phenomena, drew attention to common themes, sub-codes and the context underlying differences, and provoked necessary questions to be explored in further data collection, such as 'how', 'when' and 'why'. Descriptive accounts were produced for each batch of interviewees. These too were compared for content.

Throughout analysis an attempt was made to keep track of the emerging 'theory' by representing this as a diagrammatic conceptual framework. This also underwent several revisions. The final version is included in the discussion.

Presentation of data

Quotations are included in the results chapters to provide evidence and illustration of the themes discussed. Attempts have been made to use examples from all respondents. To promote readability, quotations have been cleaned of pauses, 'ums' and 'ahs' where this does not affect meaning or the need to convey hesitation or uncertainty. A number or full-stop in brackets indicates a pause (the number denoting length in seconds and a full-stop representing 0.5 seconds); '=' indicates there was no gap between the speakers; and .hhhhh indicates an exaggerated in or out breath. Some unimportant details such as names and locations have also been changed to preserve anonymity. Speech excluded from quotations is indicated by '...' and has been removed where this was repetitious or not relevant to the point being illustrated. At the end of each quotation, the interviewee's i.d., gender and age are indicated, for example: (5: female, 23yrs). GHQ score and CIS-R score are also given where this information is considered pertinent to interpretation.

Quality control

The need to ensure methodological rigour and quality in qualitative work is increasingly emphasised²⁹². This is reflected by the array of appraisal checklists now available for assessment of qualitative research^{284,293-296}. This chapter has provided a detailed description of the methods used in this study in order that the adequacy of these and therefore the credibility of findings and reliability of interpretation may be considered. Several strategies were employed as measures of quality control in this study, including: full tape recording and transcription of interviews; the use of computer software; application of principles of grounded theory and the constant comparative technique; investigator triangulation to check reliability of interpretations in coding and descriptive accounts; the consideration of deviant cases; and the presentation of data from the full range of respondents to illustrate the themes discussed. These are reported in the discussion (Chapter 8) and accompanied by a general consideration of issues of validity, reliability and transferability in qualitative research.

The next chapters present the research findings. The survey data are discussed first (Chapter 5) and then the qualitative findings concerning conceptions of mental illness, illness behaviour narratives and evaluations of help-sources (Chapters 6&7).

CHAPTER 5: FINDINGS FROM THE CROSS-SECTIONAL SURVEY

Introduction

A review of the literature (Chapter 3) indicates that young adults are amongst the least likely to seek help when mentally distressed, but few studies explore this in depth. The survey conducted in this study aimed to address this research gap and the results are presented in this chapter. The chapter focuses on three areas: 1) the help-seeking of GHQ cases; 2) sex differences in patterns of help-seeking amongst GHQ cases; 3) the help-seeking of those with suicidal thoughts. Findings are presented regarding the prevalence of help-seeking from formal and informal sources, and the factors associated with help-seeking. A summarised version of this chapter has been published²⁹⁷.

Characteristics of the sample

Initially, a sample of 3087 young adults was generated by Avon Health Authority (AHA) but 83 were excluded because they had been removed from the population register by the time of questionnaire administration (Chapter 4) leaving a total sample size of 3004. The known characteristics of this sample made available by AHA are displayed in Table 5.1.

Table 5.1: Sample Characteristics

CHARACTERISTIC	N	%	Mean
Gender			
Male	1503	50.03	
Female	1501	49.97	
Age			
16-19	1281	42.63	
20-24	1723	57.36	
Townsend Score			
< 0.00	1668	56.05	-0.04
≥0.00	1308	43.95	

There were equal proportions of males and females but some suggestion that the sample was skewed towards the older end of the age range studied. This is difficult to assess since a mean age for the sample was not available and the data are only available

grouped into categories of unequal width – the younger category covering four years and the older category, five. Postcode data were collected for each sampled individual and linked to census data to assign each subject a Townsend Deprivation Score as a means of gauging levels of socio-economic position (Chapter 4). These were ward based and based on a comparison with England and Wales. Townsend scores for the electoral wards of England and Wales in 1991 ranged from -6.93 to 15.40, with a mean score of zero²⁴⁷. Levels of socio-economic deprivation increase with score. In this sample, the scores ranged from -6.04 to 8.90 demonstrating that it contained individuals from a wide mix of socio-economic backgrounds but that there was greater affluence in the sample compared with England and Wales as a whole. A higher proportion of the sample had scores below zero indicating that the distribution was skewed towards lower levels of deprivation. The mean score was -0.04. Relationships between gender, age and Townsend score were explored using cross tabulations but no associations were found.

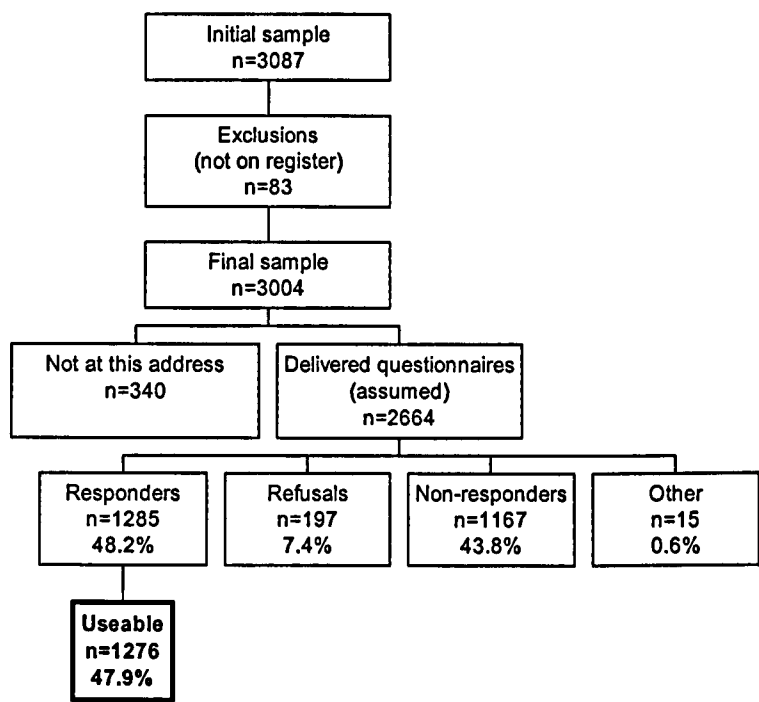
Response rates

Patterns of response are shown in figure 5.1. The overall response rate, after two reminders, was 48.2% (1285/2664). 340 (11.3%) of the 3004 questionnaires were returned marked 'not at this address' (NATA) indicating inaccuracies in the AHA register. These subjects therefore are not included in the assessment of response. There was an even number of NATA responses in males and females but substantially more amongst 20-24yrs olds (74.1%) than those aged 16-19yrs (25.9%), possibly because more of this age group are students and have increased mobility. Their mean Townsend score was -0.07 which is similar to the total sample mean (-0.04). It is assumed that the remaining 2664 questionnaires were delivered successfully, however, it is unlikely that all those undelivered were returned. More detailed investigation of the accuracy of the AHA register carried out as part of another survey conducted in Bristol at a similar time suggests that the actual number of inaccurate addresses is likely to be higher than this (13.7%, A. McCarthy, Project Manager, Chlamydia Screening Study) and so the true response rate is probably nearer 50%.

There were 197 (7.4%) refusals. Few respondents offered reasons for refusal but those given were that they disliked the subject matter or questionnaire design. Fifteen questionnaires were not completed for 'other' reasons, usually because the individual was studying away from home, travelling, or unable to complete the questionnaire due

to physical or mental disabilities. This left 1167 (43.8%) non-responders. Of the 1285 questionnaires that were returned there were 1276 useable responses. One questionnaire was spoilt and 8 could not be processed because the respondent had not signed the consent statement.

Figure 5.1: Patterns of response to the questionnaire



Response rates for each of the five batches of mail outs showed little variation ranging from 45.4% in batch 1 to 50.4% in batch 3. The lower rate for batch 1 may be because the period of administration encompassed Christmas and New Year. To test whether the vignette included in the questionnaire was causing a lower response, batch two was randomly divided and a questionnaire with the vignette excluded was sent to one half. There was little difference in response (48.5% with vignette v. 50.6% without vignette).

Non-response bias

Two attempts were made to assess non-response bias. First, the characteristics of responders and non-responders (including refusers) were compared (Table 5.2). Males, older subjects and those living in more economically deprived areas were significantly more likely to be non-responders. The characteristics of refusers were also considered separately and did not differ greatly from the overall sample characteristics, except with respect to Townsend score (-0.55) which indicated refusers lived in areas with lower

levels of deprivation but this was more similar to that of responders than non-responders. Refusers were more likely to be older (60.4% aged 20-24yrs, 39.6% aged 16 – 19 yrs) but their gender distribution was equal (49.5% male, 50.5% female).

Table 5.2: Sociodemographic characteristics of responders and non-responders

CHARACTERISTIC ⁱ	RESPONDERS (n=1285)		NON-RESPONDERS (n=1379) ⁱⁱ		χ^2
	N	Relative response rate (%)	N	Relative non-response rate (%)	
Gender					
Male (n=1333)	564	42.31	769	57.69	37.51 (p<0.001)
Female (n=1331)	721	54.17	610	45.83	
Age					
16-19 years (n=1193)	643	53.90	550	46.10	27.74 (p<0.001)
20-24 years (n=1471)	642	43.64	829	56.36	
	N	Mean	N	Mean	t
Townsend Scoreⁱⁱⁱ	1272	-0.44	1367	0.34	-6.19 (p<0.001)

ⁱ The total 'n' has been adjusted to take account of the 340 questionnaires returned 'not at this address' and therefore does not sum to the total number of questionnaires mailed (3004). Relative response rates have been calculated accordingly.
ⁱⁱ Non-responders include refusals (n=197) and those unable to complete the questionnaire (n=15), for example, due to learning difficulties.
ⁱⁱⁱ Twenty-five postcodes were not available and so Townsend score could not be assigned for these respondents. Hence numbers do not sum to the sample total.

Due to data protection issues, AHA could only release aggregate data and the extent to which non-response bias could be assessed was limited by the small number of denominator variables for which data were available. In an attempt to obtain a fuller picture of the *likely* characteristics of non-responders, those who responded to the initial mailing or first reminder ('early responders') then were compared with those who did not respond until after the second reminder ('late responders') with the assumption that these late and prompted responders might more closely resemble non-respondents (Table 5.3). The results of this crude comparison must be interpreted with caution.

Table 5.3: Summary of differences between early and late responders

VARIABLE ⁱ	TIME OF RESPONSE				TEST ⁱⁱ	
	Early (n=1030)		Late (n=246)		t/z	p
	Mean	SD	Mean	SD		
Age (n=1264)	19.55	2.37	19.97	2.25	-2.54	0.01
Townsend Score (n=1262)	-0.49	3.09	-0.32	3.25	-0.80	0.43
Confidant social support (n=1253)	19.64	4.66	19.67	4.47	0.16	0.88
GHQ score ⁱⁱⁱ (n=1268)	3.02	3.14	2.82	3.18	1.3	0.19
	EARLY (%)		LATE (%)		χ^2	p
Gender (n=1276)						
Male	41.89		51.27		6.86	0.009
Female	58.11		48.73			
Social class (n=1180)						
Non-manual	64.69		61.36		0.86	0.35
Manual	35.31		38.64			
Residency ^{iv} (n=1273)						
With Parents	73.25		64.08		8.16	0.004
With Spouse/ Partner	11.38		16.33		4.48	0.034
Alone	2.72		4.49		2.08	0.15
Occupation ^{iv} (n=1272)						
Full-time Employed	38.99		44.31		2.34	0.13
Full-time Student	47.37		39.84		4.53	0.033
Unemployed	5.95		6.50		0.11	0.74
Looking after House/ Family	4.19		4.07		0.01	0.93
Rating of general health (self-rated) (n=1271)						
Excellent/ very good	51.85		53.88		0.41	0.82
Good	36.45		35.51			
Fair/ Poor	11.70		10.61			
Usual psychological health (self-rated) (n=1265)						
Good	51.23		52.59		2.90	0.41
Okay	39.84		35.78			
Poor	7.75		9.48			
Very Poor	1.18		2.16			
Current problems (self-rated) (n=1254)	28.46		25.44		0.84	0.36
Suicidal thoughts (n=1261)	13.89		12.55		0.30	0.59
Any GP consultations (last year) (n=1274)						
None	19.26		20.76		5.07	0.17
One or two	46.92		47.46			
Three or four	20.72		23.73			
Five or more	13.10		8.05			
Past help-seeking (n=1270)						
Yes	39.96		38.52		0.17	0.68
From a GP	15.71		16.46		0.08	0.77
From friends/ family	38.54		36.59		0.32	0.57
From other ^v source	13.66		10.29		1.97	0.16
Recent help-seeking (last 4 wks) (n=1266)						
Yes	16.34		14.75		0.37	0.54
From a GP	2.94		5.33		3.44	0.06
From friends/ family	15.46		12.30		1.56	0.21
From other source ^v	2.15		1.23		0.87	0.35
Ever not sought help ^{vi} (n=1238)	29.25		27.73		0.20	0.65

ⁱ There were 1276 useable responses but missing data on some items means the total 'n' for some variables is lower.

ⁱⁱ Unpaired t-test used for 'age' and Wilcoxon rank-sum test used for 'GHQ score' and 'Confidant score' due to skewness.

ⁱⁱⁱ Arithmetic Mean used despite skewness of the distribution for the sake of comparison with other studies.

^{iv} Percentages shown do not sum to 100 per cent since not all response categories to these variables are shown in this table and in each case the options given were not all mutually exclusive so some respondents may have selected more than one category.

^v Includes voluntary sector/ self help groups, Samaritans, other telephone lines and religious help sources.

^{vi} Have you ever not sought help for a psychological or emotional problem when you think you should have done or would like to have done?"

In keeping with the available data about non-responders, late responders were older ($p=0.01$) and tended to be male (51% male late v. 42% male early, $p<0.01$), however there was no difference in the mean Townsend scores. Late responders were also more likely than early responders to be living with a spouse or partner ($p=0.03$), less likely to be living with parents ($p<0.01$), more likely to be working full-time ($p=0.13$), and less likely to be students ($p=0.03$). In a logistic regression model controlling for age, living with a spouse or partner ($p=0.14$) and living with parents ($p=0.06$) retained some strength of association but both of these associations were attenuated suggesting sociodemographic differences may in part reflect the age and gender differences between early and late responders. Early and late responders did not differ according to social class or self-rated levels of social support. The morbidity characteristics of early and late responders were similar. Approximately the same proportions thought they were suffering from psychological problems and reported suicidal thoughts. Ratings of general and psychological health were also similar. There was weak evidence to suggest that, if anything, late responders had a slightly lower mean GHQ score than early responders ($p=0.19$).

This provides some indication that the sample was not biased by having a lower than expected number of people with mental health problems. Help-seeking characteristics were also investigated revealing no differences in the proportion of early and late respondents who had sought *any* help in the past or recently (last four weeks) for a psychological problem, or reporting an episode of non-help-seeking. However, late responders were more likely to have sought help from a GP for a ‘psychological problem’ in the past four weeks (5.3% v. 2.9% early responders, $p=0.06$) raising the possibility that formal help-seekers may have been less likely to respond.

Characteristics of responders

Table 5.4 summarises the characteristics of responders as a whole group and also by gender. The mean age of responders was 19.6 years and the mean Townsend score was -0.46. Approximately two thirds were from non-manual class backgrounds. Just over 70% lived with their parents and only a small proportion with friends, a partner or spouse, or alone. Most respondents were either a student (45.9%) or in full-time employment (40%). Gender differences (all $p<0.01$) emerged in relation to Townsend score, living

arrangements and occupation. The mean Townsend score of male responders (-0.79) indicated lower levels of deprivation than females (-0.20). In keeping with age-related changes in sexual maturity and relationship patterns, males were more likely than females to be still living with their parents (77.7% v. 66.6%) and less likely to be living with a spouse or partner (8.4% v. 15.4%). Males were also more likely than females to be unemployed (8.1% v. 4.5%) and less likely to be looking after a home/family (0.5% v. 6.7%) though this applied to only a small minority of all respondents. The mean score for both types of social support was high for all respondents, though females reported significantly higher levels than males ($p<0.01$).

Psychiatric morbidity

The prevalence of probable mental disorder as measured by a score of four or more on the GHQ-12 (hereafter, GHQ cases) was 35.41% and the mean GHQ score was 2.98. In keeping with the published literature, males had lower mean GHQ scores than females (2.57 v. 3.31, $p<0.01$) and fewer were GHQ cases (31.5% v. 38.5%, $p<0.01$). These proportions are similar to those reported in a recent similar survey in Somerset²⁹. Gender differences persisted with increasing levels of GHQ score. Only 5.1% of responders scored between 10 and 12 out of 12. This was 4.3% in males and 5.8% in females ($p<0.01$). Suicidal thoughts were reported by 13.6% of respondents (14.7% males, 12.8% females, $p=0.34$). The GHQ-28 question implying the highest level of suicidal ideation – ‘found the idea of taking your own life kept coming into your head’ (Chapter 4) – was answered positively by 10.8% of respondents and approximately equal proportions of males (11.0%) and females (10.7%). Approximately 6% of respondents reported that they were currently taking medicines for psychological problems. This was similar in males and females. This included over the counter herbal remedies as well as prescription drugs and is compatible with data from the General Practice Research Database (1998)²⁹⁸ which shows rates of treated depression in 16-24 year olds of 1.6% (males) and 4.5% (females). Approximately 13% of responders had taken such medications previously.

Self-rated general and psychological health

Just over 50% of respondents rated their general health as excellent or very good while only 11.5% thought this to be fair or poor. A similar pattern emerged in relation to ‘usual’ psychological health – 51.4% perceived this to be good and just 9.5% as poor or

very poor. There were no gender differences in ratings of general and usual psychological health. Overall, 28.1% of responders thought that they were currently suffering emotional or psychological problems but in keeping with their higher GHQ caseness, more female respondents reported this than males (31.2% females v. 24.1% males, $p<0.01$). The same was true of self-reported past psychological/ emotional problems.

Help-seeking

The questionnaire enquired about the number of GP consultations attended in the last year for any reason, and also recent (during the last four weeks), and past (ever) help-seeking for psychological/ emotional problems (Table 5.4). On all measures, male respondents had sought less help ($p<0.01$). Most respondents had seen a GP once or twice in the past year, but over a quarter of male respondents compared to 14% of females reported that they had not consulted at all during this time. These proportions are lower than those reported in the 1996 Health Survey for England²⁹⁹ (47% and 25% respectively). In relation to psychological or emotional complaints, 26.1% of respondents and considerably more females than males (32.7% females v. 17.6% males, $p<0.001$) indicated that they currently perceived a need for help by either seeking help or acknowledging that they should have done so even though they had not. However, only 16% of responders had actually sought help in the previous 4 weeks. Almost 40% of responders had sought help in the past for a psychological or emotional difficulty. Female respondents were more likely than males to have sought help recently (20.2% v. 10.8%, $p<0.001$) and in the past (46.9% v. 30.4%, $p<0.001$). They were also more likely to report an occasion where they did not seek help despite thinking they should or wanting to ($p<0.01$). In total, 29.1% of responders reported such an episode of non-help-seeking.

Table 5.4: Characteristics of responders – overall and by gender

VARIABLE ⁱ	ALL	MALE	FEMALE	t/z ⁱⁱ	p
	Mean (SD)	(n=560) Mean (SD)	(n=716) Mean (SD)		
Age (n=1264)	19.63 (2.3)	19.55 (2.3)	19.69 (2.3)	-1.09	0.27
Townsend Score (n=1262)	-0.46 (3.1)	-0.79 (2.9)	-0.20 (3.2)	-3.39	<0.01
Social support					
Confidant Support (n=1253)	19.64 (4.6)	19.22 (4.5)	19.97 (4.7)	-3.50	<0.01
Affective Support (n=1261)	12.38 (2.8)	12.15 (2.7)	12.56 (2.9)	-3.82	<0.01
GHQ-12 score (n=1268)	2.98 (3.1)	2.57 (2.9)	3.31 (3.3)	-4.04	<0.01
	N (%)	N (%)	N (%)	χ^2	P
Social class (n=1180)					
Non-manual	756 (64.1)	328 (63.7)	428 (64.4)	0.06	0.81
Manual	424 (35.9)	187 (36.3)	237 (35.6)		
Residencyⁱⁱⁱ (n=1273)					
With Parents	910 (71.5)	435 (77.7)	475 (66.6)	18.82	<0.01
With Friends	198 (15.5)	91 (16.3)	107 (15.0)	0.37	0.54
With Spouse or Partner	157 (12.3)	47 (8.4)	110 (15.4)	14.36	<0.01
Alone	39 (3.1)	19 (3.4)	20 (2.8)	0.36	0.55
Occupationⁱⁱⁱ (n=1272)					
Employed Full-time	509 (40.0)	226 (40.4)	283 (39.7)	0.07	0.79
Studying Full-time	584 (45.9)	268 (47.9)	316 (44.3)	1.66	0.20
Unemployed	77 (6.0)	45 (8.1)	32 (4.5)	6.99	<0.01
Looking after house/ family	53 (4.2)	5 (0.9)	48 (6.7)	26.74	<0.01
Rating of general health (n=1271)					
Excellent/ very good	664 (52.2)	297 (53.1)	367 (51.5)	1.22	0.54
Good	461 (36.3)	194 (34.7)	267 (37.5)		
Fair/ poor	146 (11.5)	68 (12.2)	78 (11.0)		
GHQ-12 Caseness (n=1268)	449 (35.4)	175 (31.5)	274 (38.5)	6.70	0.01
GHQ bands (n=1268)					
Non-case	819 (64.6)	381 (68.5)	438 (61.5)	15.10	<0.01
Score 4 – 6	251 (19.8)	112 (20.1)	139 (19.5)		
Score 7 – 9	133 (10.5)	39 (7.0)	94 (13.2)		
Score 10 – 12	65 (5.1)	24 (4.3)	41 (5.8)		
Suicidal thoughts (n=1261)					
Yes	172 (13.6)	81 (14.7)	91 (12.8)	0.89	0.34
Thoughts of taking own life	137 (10.8)	61 (11.0)	76 (10.7)	0.04	0.85
Usual psychological health (n=1265)					
Good	650 (51.4)	290 (52.2)	360 (50.7)	0.37	0.95
Okay	495 (39.1)	212 (38.2)	283 (39.9)		
Poor	102 (8.1)	45 (8.1)	57 (8.0)		
Very poor	18 (1.4)	8 (1.4)	10 (1.4)		
Self-rated psychological problems					
Past (n=1263)	398 (31.5)	160 (28.8)	238 (33.7)	3.44	0.06
Current (n=1254)	352 (28.1)	132 (24.1)	220 (31.2)	7.64	<0.01
Psychological medicine taking					
Past (n=1261)	163 (12.9)	67 (12.1)	96 (13.6)	0.61	0.43
Current (n=1261)	74 (5.9)	33 (6.0)	41 (5.8)	0.02	0.89
GP consultations (last yr) (n=1274)					
None	250 (19.6)	149 (26.6)	101 (14.1)	64.86	<0.01
One or two	598 (46.9)	284 (50.7)	314 (44.0)		
Three or Four	273 (21.4)	89 (15.9)	184 (25.8)		
Five or more	153 (12.0)	38 (6.8)	115 (16.1)		
Help-seeking (psychological)					
Any past (n=1270)	504 (39.7)	169 (30.4)	335 (46.9)	35.12	<0.01
Any recent (n=1266)	203 (16.0)	60 (10.8)	143 (20.2)	20.46	<0.01
Perceived need (n=1266)	330 (26.1)	98 (17.6)	232 (32.7)	37.04	<0.001
Ever not sought help (n=1238)	360 (29.1)	129 (23.9)	231 (33.1)	12.51	<0.01

ⁱ There were 1276 useable responses, but missing data on some items means that the total n for some variables is slightly lower.

ⁱⁱ Unpaired t-test used for 'age' and Wilcoxon rank-sum used for 'GHQ score' and 'Confidant score' due to skewness.

ⁱⁱⁱ Percentages do not sum to 100 as the options were not mutually exclusive. Some respondents selected more than one category.

Table 5.5 displays the main sources of help used by responders recently and in the past for psychological or emotional problems.

Table 5.5: Help sources used by all respondents – overall and by gender

HELP SOURCE	ALL N (%)	MALE N (%)	FEMALE N (%)	χ^2	p
<i>Used recently (last 4 wks)</i> (male=557, female=709)					
Any help	203 (16.0)	60 (10.8)	143 (20.2)	20.46	<0.001
GP	43 (3.4)	16 (2.9)	27 (3.8)	0.83	0.36
Counsellor	15 (1.2)	5 (0.9)	10 (1.4)	0.70	0.40
Psychiatrist	6 (0.5)	3 (0.5)	3 (0.4)	0.09	0.77
Family	113 (8.9)	32 (5.7)	81 (11.4)	12.38	<0.01
Friend	158 (12.5)	42 (7.5)	115 (16.2)	21.63	<0.01
The Samaritans	1 (0.1)	0 (0.0)	1 (0.1)	0.79	0.38
Other telephone help line	1 (0.1)	1 (0.1)	0 (0.0)	1.27	0.26
Self-help/ Voluntary group	2 (0.2)	1 (0.2)	1 (0.1)	0.03	0.86
Teacher/ Employer	21 (1.7)	4 (0.7)	17 (2.4)	5.39	0.02
Other ⁱ	22 (1.7)	8 (1.4)	14 (2.0)	0.51	0.47
<i>Used in the past</i> (male=555, female=715)					
Any help	504 (39.7)	169 (30.4)	335 (46.9)	35.12	<0.001
GP	201 (15.8)	70 (12.6)	131 (18.3)	7.63	<0.01
Counsellor	125 (9.8)	40 (7.2)	85 (11.9)	7.70	<0.01
Psychiatrist	44 (3.5)	19 (3.4)	25 (3.5)	0.00	0.94
Family	358 (28.2)	113 (20.4)	245 (34.3)	29.82	<0.01
Friend	413 (32.5)	133 (24.0)	280 (39.2)	32.85	<0.01
The Samaritans	19 (1.5)	7 (1.3)	12 (1.7)	0.37	0.54
Other telephone help line	9 (0.7)	5 (0.9)	4 (0.6)	0.52	0.47
Self-help/ Voluntary group	16 (1.3)	4 (0.7)	12 (1.7)	2.30	0.13
Teacher/ Employer	136 (10.7)	45 (8.1)	91 (12.7)	6.96	<0.01
Other ⁱⁱ	43 (3.4)	12 (2.2)	31 (4.3)	4.51	0.03

ⁱ Derived from free text descriptions: partner (m=3, f=9); psychologist (m=1, f=0), social services (m=0, f=1); religious (m=0, f=1); dietician (m=0, f=1); sexual therapist (m=1, f=0), special unit (m=0, f=2); occupational therapist (m=2, f=0); colleagues (m=1, f=0).

ⁱⁱ Derived from free text descriptions: partner (m=2, f=12); psychologist (m=3, f=4); hypnotherapist (m=0, f=1); psychotherapist (m=0, f=1); social services (m=0, f=3); religious, i.e. vicar/ Jesus (m=2, f=2); sexual therapist (m=1, f=0); special unit (m=1, f=1); acupuncturist (m=1, f=1); homeopath (m=0, f=1); school nurse (m=0, f=2); health visitor (m=0, f=1); keyworker (m=0, f=1); specialist (m=1, f=0); self-help books (m=0, f=1); probation officer (m=1, f=0).

Patterns of usage are the same for recent and past help-seeking - including the rank order of sources used. A friend was the person most frequently consulted. In fact, of those who had sought help in the past 4 weeks, 72% had sought help from a friend either solely or in addition to another source. The next most frequently consulted source of help was the family, followed by a GP, an employer or teacher, then a counsellor. The order varied slightly for males' recent help-seeking, a counsellor being consulted more frequently than an employer or teacher. The ranking probably reflects access and referral as well as choice. Despite being the third most frequently consulted source of help, a GP had only been consulted by 3.4% of responders in the past 4 weeks, and 15.8% ever, but probably not many of the sample had experienced mental health problems. There was minimal use of the remaining help sources – psychiatrist, Samaritans and other

voluntary sector sources. A wide range of 'other' sources were cited (see Table) but each had been used by just a few responders.

Gender differences emerged in the usage of specific help sources. Female responders had sought more lay group help recently and in the past ($p<0.01$). The same was true of help-seeking from a teacher or employer ($p=0.02$ last 4 weeks, $p<0.01$ past). Females were no more likely than males to have sought help from a GP in the last four weeks ($p=0.36$), but more reported seeking help from a GP in the past ($p<0.01$). The same was true of seeking help from a counsellor. This is in keeping with the higher prevalence of mental disorder amongst females.

Characteristics of GHQ Cases

The main analysis focussed on the 449 respondents scoring 4 or more on the GHQ and therefore being classified as cases with probable mental disorder. Analysis explored a) the factors associated with caseness, b) the prevalence of help-seeking amongst cases, and c) factors associated with help-seeking amongst cases. The characteristics of cases are summarised in Table 5.6. The mean age of cases was 19.5 years and their mean Townsend score was -0.41. Most were female (61% v. 39% male), two thirds were from non-manual social class backgrounds and they mainly lived with their parents (68.7%). Almost half were full-time students (48.1%) and a third were in full-time employment. Their mean social support scores were 17.4 for confidant support (possible range 5-25) and 11.1 for affective support (possible range 3-15).

Morbidity characteristics of cases

The mean GHQ-12 score of cases was 6.6. More than half the cases (55.9%) scored between 4 and 6, 29.6% scored between 7 and 9, and 14.5% had scores between 10 and 12. The distribution was therefore skewed towards scores around the threshold (4) for probable disorder. Suicidal thoughts during the past few weeks were reported by 140 (31.5%) of cases and a quarter gave a positive answer to the question, 'have you recently found that the idea of taking your own life kept coming into your head?' Just 12% were taking medication for psychological/ emotional problems. Most cases rated their general health as 'excellent', 'very good' or 'good' (79.2%) and their 'usual' psychological health as 'okay' (54.2%). Just over half (56.6%) believed that they were currently suffering from psychological or emotional problems.

Factors associated with GHQ caseness

Table 5.6 also compares the characteristics of cases with non-cases in order to identify factors associated with caseness. In addition to gender (see above), the socio-demographic factors associated with GHQ caseness were occupation and social support. Cases were more likely to be unemployed (10.5% v. 3.7%, $p<0.001$). They also reported lower levels of both types of social support than non-cases. The mean confident social support score of cases was 17.4 compared to 20.8 in non-cases (diff=3.5, 95%CI 3.0 to 4.0, $p<0.0001$). Mean affective social support scores were 11.1 in cases and 13.0 in non-cases (diff=1.9, 95%CI 1.6 to 2.2, $p<0.0001$). Age, Townsend score, parental social class, and residency showed no association with caseness.

Analyses also explored the association of GHQ caseness with other indicators of actual or self-perceived mental distress (suicidal thoughts, current use of medication for psychological or emotional problems, ratings of general health and 'usual' psychological health, and perception of currently suffering from psychological/ emotional problems). Each of these variables was strongly related to GHQ caseness ($p<0.001$). Suicidal thoughts were reported by 31.5% of cases compared to 3.9% of non-cases. In fact, over 80% of those with suicidal thoughts were also GHQ-12 cases. Although only 12.0% of cases were using some form of medication to alleviate distress, the corresponding proportion in non-cases was 2.6%. Cases were more likely than non-cases to rate their general health as 'poor' (20.8% v. 6.5%) suggesting that mental distress influenced perceptions of general health, though mental distress may also have been associated with physical morbidity. A quarter of cases rated their health as 'excellent' or 'very good', however, the question was not temporally based and so may have been interpreted as referring to 'usual' health not taking account of current, possibly transient, feelings of distress. Cases were more likely than non-cases to rate their 'usual' psychological health as 'poor' or 'very poor' (21.2% v. 3.1%) and to believe they were currently suffering from psychological or emotional problems (56.6% v. 12.8%), though still over 40% of cases did not consider themselves to have a problem.

Table 5.6: Characteristics of GHQ cases and factors associated with caseness

VARIABLE ⁱ	CASES (n=449)		NON-CASES (n=819)		TEST	
	Mean	SD	Mean	SD	t/z ⁱⁱ	p
Age	19.48	2.42	19.71	2.31	1.60	0.11
Townsend Score	-0.41	3.12	-0.49	3.11	-0.40	0.69
Social Support						
Confidant score	17.38	4.94	20.85	3.94	12.22	<0.0001
Affective Score	11.13	3.17	13.05	2.36	11.06	<0.0001
GHQ Score	6.63	2.28	0.98	1.07	-29.96	<0.0001
	N (%)		N (%)		χ^2	p
Gender						
Male	175 (39.0)		381 (46.5)		6.70	0.01
Female	274 (61.0)		438 (53.5)			
Social Class						
Non-manual	270 (67.2)		482 (62.5)		2.48	0.11
Manual	132 (32.8)		289 (37.5)			
Residency ⁱⁱⁱ						
With parents	308 (68.7)		595 (72.8)		2.35	0.12
With friends	71 (15.8)		127 (15.5)		0.02	0.89
With spouse/ partner	58 (12.9)		98 (12.0)		0.24	0.62
Alone	16 (3.6)		23 (2.8)		0.55	0.46
Occupation ⁱⁱⁱ						
Work full-time	148 (33.1)		356 (43.6)		13.20	<0.001
Study full-time	215 (48.1)		367 (44.9)		1.17	0.28
Unemployed	47 (10.5)		30 (3.7)		23.65	<0.001
Home/ family	19 (4.2)		34 (4.2)		0.01	0.94
Suicidal thoughts						
Yes	140 (31.5)		32 (3.9)		186.23	<0.001
Thoughts of taking own life	111 (24.8)		26 (3.2)		140.13	<0.001
Psychological medicine-taking						
Currently	53 (12.0)		21 (2.6)		46.01	<0.001
In past	84 (19.0)		79 (9.7)		22.18	<0.001
Rating of general health ^{iv}						
Excellent/ very good	174 (38.8)		487 (59.7)		78.43	<0.001
Good	181 (40.4)		276 (33.8)			
Fair/ poor	93 (20.8)		53 (6.5)			
'Usual' psychological health ^{iv}						
Good	110 (24.5)		539 (66.0)		239.73	<0.001
Okay	243 (54.2)		252 (30.9)			
Poor	78 (17.4)		24 (2.9)			
Very poor	17 (3.8)		1 (0.1)			
Self-rated current problems	248 (56.6)		104 (12.8)		271.30	<0.001
GP consultations (last yr)						
None	60 (13.4)		189 (23.1)		56.66	<0.001
1-2	181 (40.4)		415 (50.7)			
3-4	127 (28.3)		142 (17.4)			
5 plus	80 (17.9)		72 (8.8)			
Help-seeking (psychological)						
Any past	224 (50.2)		278 (34.0)		31.79	<0.001
Any recent	132 (29.7)		69 (8.5)		97.06	<0.001
Ever not sought help	213 (49.2)		146 (18.3)		130.01	<0.001

ⁱ The caseness of 1268 respondents could be determined (8 did not complete the GHQ). Missing data on other items means that the total n for some variables is slightly lower. Range: 433-449 (cases) and 799-819 (non-cases), except social class where n=402 (cases) & 771 (non-cases).

ⁱⁱ Unpaired t-test used for 'age' and Wilcoxon rank-sum (Mann-Whitney) test used for 'Social Support Scores', 'GHQ score' and 'Suicide ideation score'. Non-parametric testing was selected to allow for the skewness of the latter distributions.

ⁱⁱⁱ Percentages shown do not sum to 100% as not all response categories are summarised and the options given were not mutually exclusive so some respondents may have selected more than one category.

^{iv} Self-rated.

Possible chronicity amongst 'non-cases'

A main reason for including the variables 'current medication taking (for psychological distress)', 'usual psychological health', and 'perceived current suffering' were as additional indicators of possible psychiatric morbidity to assess the possibility that the GHQ may not detect chronic cases (Chapter 4). Current use of medication for psychological problems was reported by 21 non-cases. Further examination of these individuals revealed that 6 were taking anti-depressants prescribed by a GP, 6 reported use of cannabis or heroin for stress relief, and 7 were using herbal remedies, mainly for 'stress', but 2 were taking St. John's Wort for depression of whom 1 was taking this as an alternative to anti-depressants prescribed by her GP. Two did not disclose what they were taking. Twenty-four non-cases rated their 'usual' psychological health as poor and 1 as very poor, and 104 thought that they were currently suffering from psychological/emotional problems. In addition, 69 non-cases had sought help for psychological/emotional problems in the last four weeks though only 6 had seen a GP, 2 a counsellor, and 1 attended a self-help group.

These data give some indication that there were a small number of chronic cases not detected by the GHQ screening and that of these some had sought help in the past 4 weeks or were involved in long-term care. In an attempt to quantify this, criteria were devised to distinguish which of these were probable chronic cases. To be assigned the status 'chronic case', respondents had to either:

- Rate their 'usual psychological health' as poor or very poor (n=25) (on the basis this definition of 'usual' tempered their GHQ responses)

and/or:

- Report current 'medicine' taking for psychological/emotional problems *and* thinking they were currently suffering from a psychological/emotional problem (n=13). This combination was used in an attempt to exclude respondents occasionally using herbal or other remedies for stress relief and appeared to achieve this objective as all those using anti-depressants or other medications prescribed by a doctor were retained in the category while those excluded included, for example, respondents reporting using: "*cannabis when I feel stressed by work*" and "*Kalms for driving lessons*".

Using these criteria, 31 non-cases were defined as likely chronic cases suggesting that approximately 4% of non-cases were misclassified (31/819). Of these, 15 were male and 16 female, and their mean age was 20.7 years. GHQ scores ranged from 0 to 3 and the mean score was 1.4. Approximately a quarter reported suicidal thoughts (n=8) and specifically thoughts of ‘taking their own life’ (n=7). Eleven (35%) had sought some help in last 4 weeks, of whom 4 (13%) had seen a GP and 1 (3%) a counsellor but these data are complicated by the fact that medicine taking was one of the criteria for identifying cases. As these suspected ‘chronic cases’ constitute such a small group of non-cases, their exclusion from the group of ‘cases’ has little effect and so they were not included in analyses of help-seeking (below), however, one was recruited for interview (*i.d.14*).

Recent help-seeking amongst GHQ-12 cases

The GHQ asks about feelings of distress over ‘the past few weeks’. Assessments of caseness are therefore confined to this time period. The variable ‘recent help-seeking’ enquired about help-seeking for psychological/ emotional problems over approximately the same time period (the last four weeks) and therefore was the measure used to assess the prevalence and patterns of help-seeking amongst GHQ cases. Five cases did not respond to the question about recent help-seeking. The following analyses are based therefore on 444 GHQ cases.

The prevalence of help-seeking

Table 5.7 shows recent help-seeking from any, and from specific help sources for all cases and cases by gender. The prevalence of any help-seeking amongst cases was 29.7% (n=132) revealing that less than a third of those with probable mental disorder had sought some form of support or assistance. The rank order of sources consulted by cases was the same as that described above for all responders, with the exception of teacher/ employer and counsellor, which were reversed. The order of the most frequently used sources was therefore friends (21.6%), family (16.0%), GP (8.3%), teacher/employer (3.6%), counsellor (2.7%). One in five cases had sought help from a friend during the previous four weeks while only one in twelve had consulted a GP. Few cases had contacted the Samaritans or other voluntary sector services (n=5, ≈ 1.0%).

Table 5.7: The prevalence of help-seeking and use of specific sources by GHQ cases in the last 4 weeks

HELP SOURCE	ALL (n=444)	MALE (n=174)	FEMALE (n=270)	p
	N (%) ⁱ	N (%) ⁱ	N (%) ⁱ	
Any help	132 (29.7)	38 (21.8)	94 (34.8)	0.003
GP	37 (8.3)	13 (7.5)	24 (8.9)	0.60
Counsellor	12 (2.7)	4 (2.3)	8 (3.0)	0.67
Psychiatrist	6 (1.3)	3 (1.7)	3 (1.1)	0.58
Family	71 (16.0)	20 (11.5)	51 (18.9)	0.04
Friend	96 (21.6)	25 (14.4)	71 (26.3)	0.003
Samaritans	1 (0.2)	-	1 (0.4)	0.42
Other telephone line	1 (0.2)	1 (0.6)	-	0.21
Self-help/ voluntary sector group	3 (0.7)	1 (0.6)	2 (0.7)	1.00
Teacher/ Employer	16 (3.6)	2 (1.1)	14 (5.2)	0.03
Other	18 (4.0)	6 (3.4)	12 (4.4)	0.60

ⁱ Percentages for use of specific sources exceed those of total help-seeking as some cases sought help from more than one source.

Help-seeking patterns therefore revealed cases had a strong preference for lay group help. Combining those seeking help from friends or family, the prevalence of help-seeking from the lay group was 25.9% (n=115) meaning that 87% (115/132) of those who sought help had sought some or all of this from informal lay sources. In contrast, the prevalence of help-seeking from a health professional (GP, counsellor, psychiatrist) (solely or in additional to other help) was 10.1% (n=45) which amounted to a third (34%) (45/132) of all help-seeking cases.

An additional indicator of recent help-seeking was whether cases were taking medication prescribed by a doctor or psychiatrist at the time of completing their questionnaire. It was thought possible that some cases – particularly those with chronic distress – may be engaged in a treatment programme with formal health services but may not have attended an appointment in the last four weeks. In such instances, due to the cross-sectional design of the questionnaire, such cases would appear as ‘non-help-seekers’. This possibility was explored by cross tabulating recent help-seeking and current medicine taking. Twenty cases classified as non-help-seekers reported current medicine taking for psychological/emotional complaints. Most of these (n=12) were self-medicating with herbal remedies or cannabis, but 8 (3 male, 5 female) were identified who were taking anti-depressants prescribed by a doctor. These cases all reported past help-seeking (previous to the last four weeks) from formal services. Their mean GHQ score was 7.6. Including these 8 cases increases the prevalence of any help-seeking to 31.5% (((132+8)/444)x100) and help-seeking from a GP to 10.1% (((37+8)/444)x100).

Sex differences

The prevalence of help-seeking was higher amongst female cases (Table 5.7). 34.8% of females compared to 21.8% of males had sought help in the previous four weeks ($p=0.003$). Although the same rank order of sources existed for males and females, sex differences did emerge in the prevalence of help-seeking from some sources. Male and female cases did not differ in their usage of health professionals. Similarly low proportions had consulted a GP (7.5% males, 8.9% females, $p=0.6$). The same was true of counsellors (2.3% v. 3.0%, $p=0.7$) and psychiatrists (1.7% v. 1.1%, $p=0.6$), though the small numbers limited the robustness of this comparison. However, female cases were significantly more likely to have sought help from friends (26.3% v. 14.4%, $p=0.003$) and family (18.9% v. 11.5%, $p=0.04$) revealing that the difference in the prevalence of help-seeking between the sexes is mainly accounted for by females' increased usage of the lay group as a source of help. In total, 30.7% of females ($n=142$) compared to 18.4% ($n=32$) of males had sought help from friends and/or family ($p=0.004$). The same sex difference emerged in relation to help-seeking from a teacher of employer (5.2% female v. 1.1% male, $p=0.03$) which could be regarded as a further lay group source. There were no sex differences in the use of voluntary or other sources though the usage of these by either sex was too small to make comparison.

Perceived need for help amongst non-help-seekers

Of the 312 cases who had not sought help, 99 (31.7%) indicated that they perceived a need for help by answering the question about recent help-seeking with the response category 'no, but I think perhaps I should have done'. This was patterned by sex. Female non-help-seekers were more likely to consider that they 'perhaps should have sought help' (39.2%) than male non-help-seekers (22.1%) ($p<0.001$).

Factors associated with help-seeking

Further analysis explored the factors associated with a) any help-seeking, b) help-seeking from a GP, and c) help-seeking from friends and/or family amongst all GHQ cases. This was achieved by simple bivariate analysis of the characteristics of help-seekers versus non-help-seekers, and then multivariable logistic regression analysis. In the analyses reported in this section, gender was included as a main effect variable. Later

analyses (below) then considered whether there were gender differences in associations with predictors of help-seeking.

Characteristics of help-seekers and non-help-seekers

Tables 5.8 to 5.10 show the results of bivariate analysis comparing the characteristics of help-seeking and non-help-seeking cases for any help-seeking, help-seeking from a GP and help-seeking from friends and family using chi-square and t-tests. These are summarised in Table 5.11

Any help-seeking

Compared to those who had sought no help (non-help-seekers), help-seekers differed on the basis of their morbidity characteristics, past help-seeking, gender and occupation (Table 5.8). Help-seekers had higher GHQ scores. Their mean score was 7.7 compared to 6.2 in non-help-seekers (diff=1.5, 95%CI 1.01 to 1.91, $p<0.001$). This difference is also shown where GHQ score is categorised into bands ($p<0.001$). A quarter of help-seekers (25.8%) compared to just 9.6% of non-help-seekers had a GHQ score between 10 and 12 while 37.9% of help-seekers and 63.1% of non-help-seekers scored between 4 and 6. Help-seekers were also more likely to report suicidal thoughts (41.7% h-s v. 27% n-h-s, $p=0.002$) and, specifically thoughts about taking their own life (34.1% h-s v. 20.6% n-h-s, $p=0.006$). In relation to self-rated morbidity status, help-seekers were more likely to believe that they had current psychological/ emotional problems (84.6% h-s v. 44.5% n-h-s, $p<0.001$), to rate their general health as fair or poor ($p=0.002$) and their 'usual' psychological health as poor or very poor ($p<0.001$). As a group, help-seekers therefore appeared to be suffering from a higher level of distress than those who did not seek help. Help-seekers were significantly more likely than non-help-seekers to have also sought help in the past (85.6% h-s v. 35.8%, $p<0.001$).

Help-seekers were more likely to be female and non-help-seekers more likely to be male ($p=0.003$). A higher proportion of help-seekers were unemployed than non-help-seekers (15.1% h-s v. 8.7% n-h-s, $p=0.04$) and a lower proportion were full-time students (40.1% h-s v. 51.6% n-h-s, $p=0.03$). There were no differences between help-seekers and non-help-seekers in terms of age, Townsend score, social support scores, residency and parental social class.

Table 5.8: Characteristics associated with any recent help-seeking in GHQ cases

VARIABLE ⁱ	HELP-SEEKERS (n=132)		NON-HELP-SEEKERS (n=312)		TEST	
	Mean	SD	Mean	SD	t/z ⁱⁱ	p
Age	19.61	2.42	19.45	2.42	-0.63	0.53
Townsend score	-0.06	3.22	-0.56	3.06	-1.55	0.12
Social Support						
Confidant	17.68	4.84	17.26	5.00	-0.74	0.46
Affective	10.92	3.23	11.23	3.17	0.93	0.35
GHQ score	7.66	2.34	6.20	2.11	-6.22	<0.001
	N (%)		N (%)		χ^2	p
Gender						
Male	38 (28.8)		136 (43.6)		8.53	0.003
Female	94 (71.2)		176 (56.4)			
Social class						
Non-manual	81 (66.9)		186 (66.9)		0.000	0.99
Manual	40 (33.1)		92 (33.1)			
Residency ⁱⁱⁱ						
With parents	85 (64.9)		219 (70.1)		1.21	0.27
With friends	22 (16.8)		49 (15.7)		0.08	0.78
With spouse/ partner	14 (10.7)		43 (13.8)		0.79	0.38
Alone	5 (3.8)		11 (3.5)		0.02	0.88
Occupation ⁱⁱⁱ						
Work full-time	43 (32.6)		103 (33.2)		0.02	0.89
Study full-time	53 (40.1)		160 (51.6)		4.87	0.027
Unemployed	20 (15.1)		27 (8.7)		4.04	0.044
Home/ family	6 (4.5)		13 (4.2)		0.03	0.87
Rating of general health ^{iv}						
Excellent	5 (3.8)		18 (5.8)			
Very good	31 (23.5)		119 (38.3)		17.17	0.002
Good	59 (44.7)		120 (38.6)			
Fair	26 (19.7)		47 (15.1)			
Poor	11 (8.3)		7 (2.2)			
GHQ bands						
4-6	50 (37.9)		197 (63.1)		29.98	<0.001
7-9	48 (36.4)		85 (27.2)			
10-12	34 (25.8)		30 (9.6)			
Suicidal thoughts						
Any	55 (41.7)		83 (27.0)		9.17	0.002
Of taking own life	45 (34.1)		64 (20.6)		12.41	0.006
Usual Psychological health ^{iv}						
Good	27 (20.4)		82 (26.4)			
Okay	64 (48.5)		175 (56.3)		21.45	<0.001
Poor	28 (21.2)		50 (16.1)			
Very poor	13 (9.8)		4 (1.3)			
Self-rated current problems	110 (84.6)		135 (44.5)		59.43	<0.001
Past help-seeking	113 (85.6)		111 (35.8)		91.99	<0.001

ⁱ Missing data on some items means that the total n for some variables is slightly lower. Range 127-132 (help-seekers) and 303-312 (non-help-seekers), except social class where n=121 (help-seekers) & 278 (non-help-seekers).

ⁱⁱ Unpaired t-test used for 'age' and Wilcoxon rank-sum (Mann-Whitney) test used for 'Social Support Scores' and 'GHQ score'. Non-parametric testing was selected to allow for the skewness of the latter distributions.

ⁱⁱⁱ Percentages do not sum to 100% as not all response categories are summarised and the options given were not mutually exclusive so some respondents may have selected more than one category.

^{iv} Self-rated.

Help-seeking from a GP

The characteristics of those seeking help from a GP (Table 5.9) were similar to those seeking help from any source but their morbidity characteristics indicated a greater gap between help-seekers and non-help-seekers in terms of their severity of distress. The mean GHQ scores of those seeking help from a GP was 9.1 compared to 6.4 amongst those who did not seek help from a GP (diff=2.7, 95% CI 1.86 to 3.41, $p<0.001$) and 48.6% of help-seekers compared to 11.3% of non-help-seekers had a score between 10 and 12 ($p<0.001$). This indicated that those who sought help from a GP had more severe mental distress. Similarly, 62.2% of those who sought help from their GP had suicidal thoughts and 45.9% thoughts about 'taking their life' compared to 28.6% and 22.7% of non-help-seekers respectively ($p<0.001$). Those seeking help from a GP were also more likely than GP non-help-seekers to consider they had current psychological/emotional problems, were more likely to rate their 'usual' psychological health as 'poor' or 'very poor' ($p<0.001$), their general health as 'fair' or 'poor' ($p<0.001$), and to have sought help for mental distress in the past (0.001)

In contrast to the patterns found for any help-seeking, there were no gender differences in help seeking from a GP ($p=0.6$). The only sociodemographic characteristic distinguishing those who had and had not sought help from a GP was being unemployed (21.6% h-s v. 9.63% n-h-s, $p=0.02$) though there was weak evidence that help seekers had lower levels of social support ($p=0.14$, 0.10) and came from more deprived areas as indicated by Townsend score ($p=0.19$). The small number of GP help-seekers ($n=37$) meant there was limited power to detect potentially important differences.

Table 5.9: Characteristics associated with recent help-seeking from a GP in GHQ cases

VARIABLE ⁱ	HELP-SEEKERS (N=37)		NON-HELP-SEEKERS (N=407)		TEST	
	Mean	SD	Mean	SD	t/z ⁱⁱ	p
Age	19.70	2.40	19.48	2.42	0.54	0.59
Townsend score	0.23	3.60	-0.47	3.07	-1.31	0.19
Social Support						
Confidant	16.28	4.25	17.49	5.00	-1.46	0.14
Affective	10.28	3.36	11.21	3.16	-1.64	0.10
GHQ score	9.05	2.33	6.42	2.15	5.99	<0.0001
	N (%)		N (%)		χ^2	p
Gender						
Male	13 (35.1)		161 (39.6)		0.28	0.60
Female	24 (64.9)		246 (60.4)			
Social class						
Non-manual	22 (62.9)		245 (67.3)		0.29	0.59
Manual	13 (37.1)		119 (32.7)			
Residency ⁱⁱⁱ						
With parents	26 (70.3)		278 (68.5)		0.05	0.82
With friends	8 (21.6)		63 (15.5)		0.94	0.33
With Spouse/ partner	2 (5.4)		55 (13.5)		2.00	0.16
Alone	2 (5.4)		14 (3.4)		0.37	0.54
Occupation ⁱⁱⁱ						
Work full-time	10 (27.0)		136 (33.6)		0.66	0.42
Study full-time	13 (35.1)		200 (49.4)		2.76	0.10
Unemployed	8 (21.6)		39 (9.6)		5.13	0.024
Home/ family	3 (8.1)		16 (3.9)		1.42	0.23
Rating of general health ^{iv}						
Excellent	1 (2.7)		22 (5.4)			
Very good	4 (10.8)		146 (36.0)		30.33	<0.001
Good	16 (43.2)		163 (40.1)			
Fair	9 (24.3)		64 (15.8)			
Poor	7 (18.9)		11 (2.7)			
GHQ bands						
4-6	7 (18.9)		24 (59.0)		42.68	<0.001
7-9	12 (32.4)		121 (29.7)			
10-12	18 (48.6)		46 (11.3)			
Suicidal thoughts						
Any	23 (62.2)		115 (28.6)		17.70	<0.001
Of taking own life	17 (45.9)		92 (22.7)		17.59	<0.001
Usual Psychological Health ^{iv}						
Good	4 (10.8)		105 (25.9)			
Okay	13 (35.1)		226 (55.7)		44.08	<0.001
Poor	12 (32.4)		66 (16.3)			
Very poor	8 (21.6)		9 (2.2)			
Self-rated current problems	34 (91.9)		211 (53.3)		20.53	<0.001
Past help-seeking	30 (81.1)		194 (47.9)		15.11	0.001

ⁱ Missing data on some items means that the total n for some variables is slightly lower: range 35-37 (help-seekers), 396-407 (non-help-seekers), except social class where n=35 (help-seekers) & 364 (non-help-seekers).

ⁱⁱ Unpaired t-test used for age and Wilcoxon rank-sum (Mann-Whitney) test used for Social Support Scores and GHQ score. Non-parametric testing was selected to allow for the skewness of the latter distributions.

ⁱⁱⁱ Percentages do not sum to 100% as not all response categories are summarised and the options given were not mutually exclusive so some respondents may have selected more than one category.

^{iv} Self-rated.

Help-seeking from friends and family

Fewer factors appeared to distinguish those who did and did not seek help from friends and family (Table 5.10) and the differences in illness severity and morbidity characteristics between help-seekers and non-help-seekers were less marked. Although the differences between mean GHQ scores (diff=1.1, 95% CI 0.66 to 1.61, $p<0.0001$) and the proportion of cases in each 'GHQ band' ($p=0.001$) were significant these were smaller, indicating that an individual has a lower threshold of severity for seeking help from friends and family. There was only weak evidence that those with suicidal thoughts were more likely to seek help from friends or family ($p=0.17$). Help-seekers were more likely to consider that they were currently suffering from psychological/emotional problems but in contrast to GP help-seeking and help-seeking from any source, those seeking help from friends and family did not rate their 'usual' psychological or general health differently to non-help-seekers. This could indicate that friends and family are more likely than other help sources to be consulted in the early stages of distress, for transient experiences, or less severe distress that does not alter perceptions of well-being. As with help-seeking from other sources, those seeking help from friends and family were considerably more likely to have also sought help in the past ($p<0.001$).

Gender was the only socio-demographic characteristic associated with help-seeking from friends and family. Female cases were more likely to seek help from friends and family than males ($p=0.004$).

Table 5.10: Characteristics associated with recent help-seeking from friends and family in GHQ cases

VARIABLE ⁱ	HELP-SEEKERS (N=115)		NON-HELP-SEEKERS (N=329)		TEST	
	Mean	SD	Mean	SD	t/z ⁱⁱ	p
Age	19.50	2.37	19.50	2.44	0.001	1.00
Townsend score	0.00	3.26	-0.55	3.06	1.62	0.10
Social Support						
Confidant	17.68	5.17	17.28	4.88	0.84	0.40
Affective	11.09	3.16	11.15	3.20	-0.24	0.81
GHQ score	7.48	2.22	6.34	2.23	5.00	<0.0001
	N (%)		N (%)		χ^2	p
Gender						
Male	32 (27.8)		142 (43.2)		8.41	0.004
Female	83 (72.2)		187 (56.8)			
Social class						
Non-manual	73 (69.5)		194 (66.0)		0.44	0.51
Manual	32 (30.5)		100 (34.0)			
Residency ⁱⁱⁱ						
With parents	73 (64.0)		231 (70.2)		1.50	0.22
With friends	20 (17.5)		51 (15.5)		0.26	0.61
With spouse/ partner	12 (10.5)		45 (13.7)		0.75	0.39
Alone	3 (2.6)		13 (3.9)		0.42	0.51
Occupation ⁱⁱⁱ						
Work full-time	36 (31.6)		110 (33.5)		0.15	0.70
Study full-time	52 (45.6)		161 (49.1)		0.41	0.52
Unemployed	12 (11.4)		34 (10.4)		0.09	0.76
Home/ family	3 (7.0)		11 (3.3)		2.76	0.10
Rating of general health ^{iv}						
Excellent	4 (3.5)		19 (5.8)			
Very good	31 (27.0)		119 (36.3)		5.82	0.21
Good	52 (45.2)		127 (38.7)			
Fair	21 (18.3)		52 (15.8)			
Poor	7 (6.1)		11 (3.3)			
GHQ bands						
4-6	47 (40.9)		200 (60.8)		14.72	0.001
7-9	43 (37.4)		90 (27.4)			
10-12	25 (21.7)		39 (11.8)			
Suicidal thoughts						
Any	42 (36.5)		96 (29.6)		1.87	0.17
Of taking own life	36 (31.3)		72 (22.0)			
Usual Psychological Health ^{iv}						
Good	24 (20.9)		85 (25.9)			
Okay	60 (52.2)		179 (54.6)		3.96	0.27
Poor	24 (20.9)		54 (16.5)			
Very poor	7 (6.1)		10 (3.0)			
Self-rated current problems	94 (83.2)		151 (47.2)		44.05	<0.001
Past help-seeking	95 (82.6)		129 (39.4)		63.41	<0.001

ⁱ Missing data on some items means that the total n for some variables is slightly lower – range 111-115 (help-seekers) 320-329 (non-help-seekers), except social class where n=105 (help-seekers) & 294 (non-help-seekers).

ⁱⁱ Unpaired t-test used for age and Wilcoxon rank-sum (Mann-Whitney) test used for social support and GHQ score. Non-parametric testing was selected to allow for the skewness of the latter distributions.

ⁱⁱⁱ Percentages do not sum to 100 per cent since not all response categories are summarised and in each case the options given were mutually exclusive so some respondents may therefore have selected more than one category.

^{iv} Self-rated.

Table 5.11: Summary: characteristics associated with help-seeking($p<0.05$) in bivariate analysis

	Any	GP	F&F
<i>Socio-demographic</i>			
Female	■		■
Unemployed	■	■	
Full-time student	■		
<i>Morbidity</i>			
Poor general health	■	■	
Higher GHQ score	■	■	■
Suicidal thoughts	■	■	
Poor 'usual' psychological health	■	■	
Perception of current problem	■	■	■
Past help-seeking	■	■	■

Multivariable analysis of factors associated with help-seeking

Logistic regression models were used to explore further the factors associated with help-seeking by cases. As previously, analyses were carried out for any help-seeking, help-seeking from a GP and help-seeking from friends and family. Associations with each individual factor were assessed in separate models, before and after controlling for GHQ score.

Severity and help-seeking

Logistic regression analysis confirmed the finding identified by bivariate analysis that illness severity (measured by GHQ score) was strongly associated with help-seeking (Table 5.12).

Table 5.12: Odds ratios of the association between GHQ-12 score and recent help-seeking amongst cases

Help-source GHQ Score	Any		GP		Friends and family	
	OR	95%CI	OR	95%CI	OR	95% CI
4-6	1.00		1.00		1.00	
7-9	2.22	1.39 – 3.56	3.40	1.30 – 8.86	2.03	1.25 – 3.29
10-12	4.46	2.50 – 7.98	13.42	5.30 – 33.94	2.73	1.51 – 4.94
p-value	<0.0001		<0.0001		0.0007	

Compared to cases scoring 4-6 on the GHQ-12, those scoring 7-9 were two times more likely (OR 2.2, 95%CI 1.4 to 3.6), and those scoring 10-12 were four and a half times more likely (OR 4.5, 95%CI 2.5 to 8.0) to have sought some help. This pattern was even more pronounced for help-seeking from a GP. Compared to those with GHQ score of 4-6, the

odds ratio of consulting a GP with a score of 7-9 was 3.4 (95%CI 1.30 to 8.86) and with a score of 10-12 the odds ratio was 13.4 (95%CI 5.3 to 33.9). GHQ score was also associated with help-seeking from friends and family though, of the three forms of help-seeking examined, its affect on lay help-seeking appeared least strong. Severity therefore appeared to be most important to formal help-seeking.

Due to this association, further results for regression analysis (Tables 5.13-5.15) are presented before and after controlling for GHQ-12 score by fitting this as a continuous term in the models. Controlling for GHQ score made it possible to assess factors associated with help-seeking independent from illness severity.

Any help-seeking

After controlling for GHQ score, five factors were associated with any help-seeking at the 5% level of statistical significance (Table 5.13). These were gender, social support, self-rated health, the perception of currently suffering from a psychological or emotional problem, and having sought help in the past for psychological or emotional problems. Compared to male cases, female cases were over one and a half times more likely to seek help (OR 1.7, 95%CI 1.1 to 2.7, $p=0.02$). The likelihood of help-seeking amongst all cases increased as scores for self-rated confidant social support also increased ($p=0.05$), but this affect was less clear with affective social support ($p=0.2$). Cases who rated their general health as just fair or poor were twice as likely to seek help than those rating this as excellent or very good (95% CI 1.1 to 3.7, $p=0.02$). Believing oneself to have a psychological or emotional problem and having sought help in the past were the strongest predictors of any recent help-seeking with odds ratios of 5.3 (95%CI 3.1 to 9.2, $p<0.0001$) and 10.3 (95%CI 5.9 to 18.0, $p<0.0001$) respectively. All other factors, including the existence of suicidal thoughts only showed weak association with help-seeking.

Table 5.13: Odds ratios (unadjusted and adjusted for GHQ score) of factors associated with any recent help-seeking in GHQ cases

VARIABLE ⁱ	Unadjusted Odds Ratios		Adjusted for GHQ Score		
	OR	95% C.I.	OR	95% C.I.	p
Age					
16-19 years	1.00		1.00		
20-24 years	0.97	0.65 – 1.46	0.91	0.60 – 1.40	0.68
Gender					
Male	1.00		1.00		
Female	1.91	1.23 – 2.96	1.70	1.08 – 2.68	0.02
Parental social class					
Non-manual	1.00		1.00		
Manual	1.00	0.63 – 1.57	1.04	0.65 – 1.68	0.86
Townsend score					
Less than 0	1.00		1.00		
More than 0	1.28	0.84 – 1.94	1.19	0.77 – 1.84	0.44
Residency					
Parents	1.00		1.00		
Spouse/ partner	0.83	0.43 – 1.60	0.83	0.42 – 1.64	
Friends	1.19	0.68 – 2.09	1.21	0.67 – 2.17	
Other ⁱⁱ	1.91	0.98 – 3.71	1.65	0.82 – 3.33	0.42
Occupation					
Employed (ft)	1.00		1.00		
Study (ft)	0.82	0.49 – 1.38	0.73	0.42 – 1.26	
Employed/ Study (pt)	0.99	0.57 – 1.72	0.95	0.54 – 1.70	
Unemployed	2.24	1.06 – 4.75	1.71	0.76 – 3.83	
House and/ or family	1.02	0.25 – 4.11	0.62	0.14 – 2.67	
Other ⁱⁱⁱ	0.79	0.20 – 3.06	0.65	0.16 – 2.73	0.42
Social Support					
Confidant Score					
5-9	0.77	0.61 – 1.62	0.27	0.09 – 0.80	
10-14	0.91	0.52 – 1.57	0.59	0.33 – 1.08	
15-19	0.99	0.29 – 2.07	0.91	0.54 – 1.52	
20-25	1.00		1.00		0.047
Affective Score					
3-5	1.57	0.68 – 3.63	0.73	0.29 – 1.84	
6-8	0.89	0.49 – 1.62	0.69	0.37 – 1.29	
9-11	1.51	0.93 – 2.47	1.34	0.80 – 2.24	
12-15	1.00		1.00		0.23
Rating of Health					
Excellent/ very good	1.00		1.00		
Good	1.87	1.16 – 3.03	1.80	1.09 – 2.96	
Fair/ Poor	2.61	1.49 – 4.55	2.05	1.14 – 3.69	0.02
Rating of Usual Psychological Health					
Good	1.00		1.00		
Okay	1.11	0.66 – 1.87	1.02	0.59 – 1.75	
Poor/ very poor	2.31	1.27 – 4.18	1.26	0.65 – 2.44	0.72
Current problems					
No	1.00		1.00		
Yes	6.84	4.04 – 11.60	5.32	3.09 – 9.17	0.0000
Suicidal thoughts					
No	1.00		1.00		
Yes	1.93	1.26 – 2.96	1.28	0.80 – 2.05	0.31
Past Help-Seeking					
No	1.00		1.00		
Yes	10.66	6.22 – 18.27	10.30	5.91 – 17.97	<0.0001

ⁱ Missing data on some items means the total n for some variables is slightly lower. Range 433-444, except social class where n=399.

ⁱⁱ Other includes those living with grandparents, single parents living with their own children, those living in work staff accommodation and a small number of other miscellaneous responses provided by respondents.

ⁱⁱⁱ Includes those unable to work due to disability or ill health.

Help-seeking from a GP

After controlling for GHQ score, a number of factors remained important to the likelihood of GP help-seeking (Table 5.14). Those who believed they were suffering from psychological/ emotional problems were five and a half times more likely to seek help than those who did not (OR 5.6, 95%CI 1.6 to 19.2, $p=0.001$). Similarly, the odds of consulting increased as ratings of general health worsened - those regarding their general health to be fair or poor were four and a half times more likely to seek help than those rating this as excellent or very good (OR 4.6, 95%CI 1.56 to 13.85, $p=0.01$). Those who had sought any help in the past for psychological/emotional problems were four times more likely to have recently consulted a GP than those who had not (OR 4.0, 95%CI 1.67 to 9.8, $p<0.001$).

Weaker evidence also indicated that cases with suicidal thoughts were twice as likely to seek help compared to those who did not report suicidal thoughts (OR 2.1, 95%CI 0.98 to 4.53, $p=0.06$), and that those considering their 'usual' psychological health to be poor or very poor also had increased odds of seeking help from a GP compared to those perceiving this to be good or okay ($p=0.09$). Sociodemographic factors, including gender, were not strongly associated with help-seeking. However, there was weak evidence to suggest that those considering themselves to have poor confidant support amongst their social networks were less likely to seek help from a GP, while those scoring towards but not at the upper end of the confidant support scale were two times more likely to seek help ($p=0.09$). This may suggest that lay referral was important in motivating individuals to seek formal help.

Due to the small number of GP help-seeking cases involved ($n=37$) these analyses lack power to detect potentially important associations.

Table 5.14: Odds ratios (unadjusted and adjusted for GHQ score) of factors associated with recent help-seeking from a GP in GHQ cases

VARIABLE ⁱ	Unadjusted Odds Ratios		Adjusted for GHQ Score		
	OR	95% C.I.	OR	95% C.I.	p
Age					
16-19 years	1.00				
20-24 years	0.91	0.46 – 1.78	0.75	0.36 – 1.56	0.44
Gender					
Male	1.00				
Female	1.21	0.60 – 2.44	0.99	0.46 – 2.10	0.97
Parental social class					
Non-manual	1.00				
Manual	1.22	0.59 – 2.50	1.32	0.61 – 2.88	0.48
Townsend score					
Less than 0	1.00		1.00		
More than 0	1.49	0.76 – 2.93	1.32	0.64 – 2.72	0.44
Residency					
Parents	1.00		1.00		
Spouse/ partner	0.44	0.10 – 1.91	0.42	0.09 – 1.96	
Friends	1.50	0.63 – 3.54	1.64	0.65 – 4.14	
Other ⁱⁱ	2.00	0.76 – 5.29	1.51	0.52 – 4.34	0.31
Occupation					
Employed (ft)	1.00		1.00		
Study (ft)	0.93	0.36 – 2.35	0.77	0.29 – 2.06	
Employed/ study (pt)	0.99	0.36 – 2.71	0.98	0.34 – 2.80	
Unemployed	4.00	1.45 – 11.06	2.39	0.77 – 7.38	
House and/ or family	3.37	0.63 – 18.06	1.79	0.29 – 10.95	
Other ⁱⁱⁱ	1.23	0.14 – 10.49	0.87	0.88 – 8.69	0.54
Social Support					
Confidant Score					
5-9	1.68	0.33 – 8.49	0.41	0.07 – 2.26	
10-14	1.99	0.75 – 5.25	1.13	0.40 – 3.21	
15-19	2.21	0.91 – 5.36	2.25	0.87 – 5.83	
20-25	1.00		1.00		0.09
Affective Score					
3-5	3.23	1.06 – 9.85	1.04	0.30 – 3.55	
6-8	1.22	0.45 – 3.26	0.87	0.31 – 2.47	
9-11	1.45	0.63 – 3.35	1.27	0.52 – 3.05	
12-15	1.00				0.92
Rating of Health					
Excellent/ very good	1.00				
Good	3.30	1.18 – 9.21	3.11	1.08 – 8.94	
Fair/ poor	7.17	2.53 – 20.29	4.65	1.56 – 13.85	0.01
Rating of Usual Psychological Health					
Good	1.00				
Okay	1.51	0.48 – 4.75	1.39	0.43 – 4.50	
Poor/ very poor	7.00	2.20 – 22.31	2.99	0.92 – 9.77	0.09
Current Problems					
No	1.00				
Yes	9.94	3.00 – 32.89	5.62	1.64 – 19.21	0.001
Suicidal Thoughts					
No	1.00				
Yes	4.10	2.01 – 8.37	2.10	0.98 – 4.53	0.056
Past Help-Seeking					
No	1.00		1.00		
Yes	4.66	2.00 – 10.86	4.05	1.67 – 9.82	<0.001

ⁱ Missing data on some items means the total n for some variables is slightly lower: range 433-444, except social class where n=399.

ⁱⁱ Other includes those living with grandparents, single parents living with their own children, those living in work staff accommodation and a small number of other miscellaneous responses provided by respondents.

ⁱⁱⁱ Includes those unable to work due to disability or ill health.

Help-seeking from friends and family

After controlling for GHQ score, three variables were strongly associated with help-seeking from friends and family (Table 5.15). Cases who had previously sought some form of help for psychological or emotional problems were nearly seven times more likely to have recently sought help from friends or family (OR 6.7, 95%CI 3.9 to 11.5, $p<0.0001$). Those who thought themselves to be suffering currently from a psychological or emotional problem were over four and a half times more likely to consult friends and family (OR 4.6, 95%CI 2.6 to 8.0, $p<0.0001$). Thirdly, regression analysis confirmed that females were more likely than males to seek lay support (OR 1.8, 95%CI 1.1 to 2.9, $p=0.01$). As with other forms of help-seeking the sociodemographic variables age, parental social class, Townsend score, and residency were not strongly associated, but in contrast to other forms of help-seeking, neither were social support, self-rated health, occupation, self-rated usual psychological health or suicidal thoughts. In fact, the morbidity characteristics self-rated usual psychological health and suicidal thoughts showed essentially no association.

Table 5.15: Odds ratios (unadjusted and adjusted for GHQ score) of factors associated with recent help-seeking from friends and family in GHQ cases

VARIABLE ⁱ	Unadjusted Odds Ratios		Adjusted for GHQ Score		
	OR	95% C.I.	OR	95% C.I.	p
Age					
16-19 years	1.00				
20-24 years	0.89	0.58 – 1.37	0.85	0.55 – 1.31	0.46
Gender					
Male	1.00				
Female	1.97	1.24 – 3.13	1.79	1.11 – 2.87	0.01
Parental social class					
Manual	1.00				
Non-manual	0.85	0.53 – 1.37	0.87	0.53 – 1.42	0.58
Townsend score					
Less than 0	1.00				
More than 0	1.29	0.84 – 1.99	1.22	0.78 – 1.90	0.39
Residency					
Parents	1.00		1.00		
Spouse/ Partner	0.85	0.43 – 1.71	0.85	0.42 – 1.74	
Friends	1.32	0.74 – 2.35	1.33	0.74 – 2.41	
Other ⁱⁱ	1.60	0.79 – 3.22	1.39	0.68 – 2.87	0.58
Occupation					
Employed (ft)	1.00		1.00		
Study (ft)	1.05	0.61 – 1.79	0.97	0.56 – 1.68	
Employed/ Study (pt)	0.98	0.55 – 1.77	0.96	0.52 – 1.74	
Unemployed	1.21	0.53 – 2.76	0.90	0.38 – 2.15	
House and/ or Family	1.30	0.32 – 5.28	0.89	0.21 – 3.79	
Other ⁱⁱⁱ	0.60	0.13 – 2.89	0.52	0.10 – 2.58	0.98
Social Support					
Confidant Score					
5-9	0.93	0.35 – 2.52	0.77	0.46 – 1.31	
10-14	0.90	0.51 – 1.60	0.61	0.33 – 1.13	
15-19	0.89	0.53 – 1.49	0.51	0.18 – 1.42	
20-25	1.00		1.00		0.35
Affective Score					
3-5	1.07	0.43 – 2.68	0.56	0.21 – 1.50	
6-8	0.82	0.44 – 1.53	0.71	0.38 – 1.35	
9-11	1.24	0.74 – 2.07	1.14	0.67 – 1.92	
12-15	1.00		1.00		0.37
Rating of Health					
Excellent/ very good	1.00		1.00		
Good	1.61	0.99 – 2.64	1.54	0.93 – 2.55	
Fair/ Poor	1.75	0.98 – 3.13	1.40	0.77 – 2.56	0.22
Rating of Usual Psychological Health					
Good	1.00		1.00		
Okay	1.19	0.69 – 2.03	1.11	0.64 – 1.93	
Poor/ very poor	1.71	0.92 – 3.20	1.02	0.52 – 2.03	0.91
Current Problems					
No	1.00		1.00		
Yes	5.54	3.23 – 9.50	4.60	2.64 – 8.04	<0.0001
Suicidal Thoughts					
No	1.00		1.00		
Yes	1.37	0.87 – 2.14	0.95	0.58 – 1.56	0.84
Past Help-Seeking					
No	1.00		1.00		
Yes	7.29	4.29 – 12.40	6.75	3.94 – 11.55	<0.0001

ⁱ Missing data on some items means the total n for some variables is slightly lower: range 433-444, except social class where n=399.

ⁱⁱ Other includes those living with grandparents, single parents living with their own children, those living in work staff accommodation and a small number of other miscellaneous responses provided by respondents.

ⁱⁱⁱ Includes those unable to work due to disability or ill health.

Summary

Severity (GHQ score) was most strongly associated with help-seeking, particularly where the help-source is a GP. Factors associated with help-seeking independent of severity are summarised in Table 5.16. A perception of having problems and having sought help in the past were related to help-seeking from all the sources examined. Being female was associated with help-seeking from friends and family but not a GP, while morbidity factors were more important to help-seeking from a GP. The association of help-seeking and unemployment was largely explained by GHQ score.

Table 5.16: Factors associated with help-seeking after controlling for GHQ score

	Any	GP	F&F
<i>Socio-demographic</i>			
Female	■		■
Increased social support	■	□	
<i>Morbidity</i>			
Poor general health	■	■	
Suicidal thoughts		□	
Poor 'usual' psychological health		□	
Perception of current problem	■	■	■
Past help-seeking	■	■	■
Key: ■ = p<0.05, □ = p<0.10			

Sex differences in help-seeking by GHQ cases

The analyses described above revealed that:

1. Overall, 34.8% of female cases compared to just 21.8% of male cases had sought some help in the past 4 weeks (difference=13%, 95%CI = 4.6% to 21.3%, p=0.003).
2. Females were more likely to seek help from friends and family (OR 1.8) but there was no difference in the proportions of each sex consulting a GP (OR 0.99).

These and other potential sex differences were explored further by repeating the analyses of GHQ cases described above for male and female GHQ cases separately.

Sex differences in the characteristics of help-seekers

Mainly, there was much consistency in the characteristics of male and female help-seekers and these were in keeping with those described above for all help-seekers. However, important sex differences emerged in relation to GHQ score.

While GHQ score was strongly associated with help-seeking in both sexes (help-seekers having higher mean scores than non-help-seekers), in each case the strength of association was greater for males and the threshold for help-seeking was higher in males than females. This is illustrated by examining the differences in mean GHQ score between help-seekers (h-s) and non-help-seekers (n-h-s) for each sex (Table 5.17) and by comparing the mean GHQ score of help-seeking males and females (Table 5.18).

Table 5.17: Mean GHQ scores of help-seeking and non-help-seeking cases in males and females

HELP SOURCE	MALES (n=174) mean GHQ score				FEMALES (n=270) mean GHQ score			
	H-S	N-H-S	Diff	95% CI, p	H-S	N-H-S	Diff	95% CI, p
Any	7.89	5.78	2.11	1.33 – 2.89 p<0.0001	7.56	6.53	1.03	0.49 - 1.58 p<0.0002
GP	10.00	5.94	4.06	2.89 – 5.23 p<0.0001	8.54	6.73	1.81	0.90 – 2.73 p<0.0001
Friends/ Family	7.62	5.93	1.69	0.83 – 2.55 p=0.0001	7.42	6.65	0.77	0.20 – 1.34 p=0.008

Table 5.17 shows a larger difference in mean GHQ score between help-seeking and non-help-seeking males than the corresponding difference in females. This suggests that severity played a greater role in determining help-seeking in male than female cases.

Table 5.18: Mean GHQ score of help-seeking cases by gender

HELP SOURCE	Mean GHQ score male help-seekers	Mean GHQ score female help-seekers	Diff	95% CI, p
Any	7.89	7.56	0.33	-0.56 to 1.22 p=0.46
GP	10.00	8.54	1.46	-0.2 to 3.1 p=0.07
Friends/ Family	7.62	7.42	0.20	-0.8 to 1.2 p=0.69

The mean GHQ score of male help-seekers is also larger than the corresponding score in female help-seekers (Table 5.18) suggesting that males had a higher threshold of severity before they would seek help.

These differences are most evident for help-seeking from a GP where the difference in the mean GHQ score of help-seeking and non-help-seeking males is 4.1 (95%CI 2.9 to

5.2) compared to 1.8 (95%CI 0.9 to 2.7) in help-seeking versus non-help-seeking females. The mean GHQ score of male GP help-seekers was 10 compared to 8.5 in females providing some (weak) evidence of a sex difference in thresholds of help-seeking (difference 1.5, 95% CI -0.2 to 3.1, $p=0.07$). The difference in mean GHQ score between male and female friends and family help-seekers was not significant ($p=0.69$) probably because severity was least important in predicting this form of help-seeking (see above).

Multivariable analysis of factors associated with help-seeking in male and female GHQ cases

As for all GHQ cases, the characteristics of help-seeking and non-help-seeking male and female cases were investigated further (separately) using logistic regression analysis (Tables 5.19-5.22). First, the association of GHQ score and help-seeking was explored in more detail, given the indication that this was the strongest predictor of help-seeking and may have a greater effect in men than women. Further analysis then controlled for GHQ score (case severity) by fitting this as a continuous term. Initially, associations with each individual factor were assessed in separate models. Factors associated ($p<0.10$) with help-seeking in these preliminary models were then entered together in final multivariable models. Analysis focussed on help-seeking from a GP and help-seeking from friends and family.

Help-seeking from a GP

An interaction term was fitted to explore further the apparent sex differences in GHQ score and help-seeking from a GP. This provided evidence that the association of GHQ score with help-seeking from a GP differed in men and women ($p=0.03$). The direction of this interaction was such that the likelihood of help-seeking in relation to increase in GHQ score (severity) was higher in males than females. The odds ratio for GP help-seeking per unit increase in GHQ score was 2.1 in males (95%CI 1.7 to 2.7, $p<0.0001$) and 1.4 in females (95%CI 1.2 to 1.7, $p=0.0001$). This reaffirmed findings (above) suggesting that severity was more important in determining help-seeking in male than females cases and that males had a higher threshold of severity for seeking help. This also reinforced the importance of controlling for GHQ score in further analysis of the factors associated with help-seeking from a GP.

Table 5.19 presents the findings of a logistic regression analysis (controlling for GHQ score) of additional factors associated with seeking help from a GP amongst male and female cases (separately). Both males and females appeared approximately four times more likely to consult a GP if they had sought help (from any source) for psychological or emotional problems in the past (males: OR 4.2, 95% CI 0.9 to 18.9, $p=0.04$; females: OR 3.8, 95%CI 1.2 to 11.7, $p=0.01$). There was also weak evidence that parental social class influenced GP help-seeking in both sexes but in opposing directions. Other factors predicted help-seeking from a GP in female but not male cases. These were recognition that they were suffering from a mental health problem (OR 6.5, $p=0.002$), suicidal thoughts (OR 3.0, $p=0.02$) and self-reported poor health (OR 1.0 (ref category compared to 0.1 excellent/ very good, $p=0.004$)). However, there was a higher number of female cases which may have meant there was greater power to detect differences. The data for males in relation to these variables are consistent with the patterns shown in females, but are undermined by wide confidence intervals. Tests for interaction between gender and each of these variables in relation to GP help-seeking confirm this view (current suffering, $p=0.8$; suicidal thoughts, $p=0.6$; self-rated health, $p=0.8$). No significant associations were found for either sex between GP help-seeking and age, residency, occupation, Townsend score, social support, or self-rated 'usual' psychological health.

Factors associated ($p<0.10$) with help-seeking in these preliminary analysis were entered together in final multivariable models (Table 5.20). In males, the model included parental social class and past help-seeking and there was no evidence that the association with either of these factors was attenuated by controlling for the other. Five factors were entered into the model for females (parental social class, past help-seeking, self-rated general health, recognition of current problems and suicidal thoughts). In this model, associations with parental social class, self-rated health and past help-seeking were little changed, but the association with recognition of current problems and suicidal thoughts was much attenuated.

Table 5.19: Odds ratios (adjusted for GHQ score) of factors associated with help-seeking from a GP in the last four weeks by male and female GHQ cases

VARIABLE	MALE (n=168-174) ⁱ			FEMALE (n=264-270) ⁱ		
	OR	95% C.I.	p	OR	95% C.I.	p
Age						
16-19 years	1.00			1.00		
20-24 years	1.00	0.26 – 3.78	1.00	0.69	0.28 – 1.68	0.41
Residency						
Parents	1.00			1.00		
Spouse/ partner	1.00	0.08 – 11.70		0.27	0.03 – 2.16	
Friends	1.46	0.28 – 7.61		1.84	0.59 – 5.70	
Other ⁱⁱ	2.21	0.32 – 15.02	0.86	1.12	0.29 – 4.34	0.28
Occupation						
Employed (ft/pt)	1.00			1.00		
Study (ft/pt)	0.72	0.13 – 3.87		0.74	0.28 – 2.00	
Other ⁱⁱⁱ	1.62	0.25 – 10.61	0.97	1.33	0.42 – 4.22	0.61
Parental Social Class^{iv}						
Non-manual	1.00			1.00		
Manual	0.18	0.02 – 1.82	0.09	2.25	0.91 – 5.54	0.08
Townsend Score						
< 0 (affluent areas)	1.00			1.00		
≥ 0 (poor areas)	1.34	0.34 – 5.29	0.68	1.25	0.53 – 2.97	0.61
Social Support						
Confidant Score						
5-9	0.23	0.01 – 4.25		0.42	0.04 – 4.05	
10-14	0.18	0.02 – 2.05		1.83	0.58 – 5.80	
15-19	1.29	0.18 – 9.46		1.98	0.63 – 6.19	
20-25	1.00		0.13	1.00		0.31
Affective Score						
3-5	2.14	0.27 – 16.62		0.71	0.12 – 3.99	
6-8	0.40	0.04 – 4.33		1.17	0.37 – 3.77	
9-11	1.76	0.35 – 8.86		1.22	0.41 – 3.63	
12-15	1.00		0.53	1.00		0.93
Rating of Health						
Excellent/ Very good	0.44	0.08 – 2.39		0.11	0.02 – 0.54	
Good	0.56	0.11 – 2.79		0.64	0.24 – 1.70	
Fair/ poor	1.00		0.61	1.00		0.004
Rating of Usual Psychological Health						
Good	1.00			1.00		
Okay	2.57	0.20 – 32.84		1.32	0.35 – 5.06	
Poor/ very poor	4.72	0.47 – 47.43	0.32	2.95	0.71 – 12.28	0.20
Current Problems						
No	1.00			1.00		
Yes	2.89	0.29 – 28.39	0.33	6.51	1.47 – 28.85	0.002
Suicidal Thoughts						
No	1.00			1.00		
Yes	1.22	0.30 – 4.86	0.78	3.02	1.16 – 7.82	0.02
Past Help-Seeking						
No	1.00			1.00		
Yes	4.24	0.95 – 18.86	0.04	3.79	1.22 – 11.74	0.01

ⁱ The sample size varies slightly for each variable due to missing data on some items.

ⁱⁱ Includes those living alone, single parents and a small number of miscellaneous responses.

ⁱⁱⁱ Includes unemployed, looking after home/ family and not working due to sickness/disability.

^{iv} Missing data on this variable gave a total of 155 in males and 244 in females.

Table 5.20: Help-seeking from a GP: preliminary and multivariable analysis of factors associated with GHQ cases' help-seeking in the last four weeks adjusted for GHQ score

MALES						
VARIABLE	Preliminary models (n=154)			Final multivariable model (n=154)		
	OR	95% C.I.	p-value	OR	95% C.I.	p-value
Parental Social Class						
Non-Manual	1.00			1.00		
Manual	0.18	0.02 – 1.82	0.09	0.16	0.01 – 2.02	0.11
Past Help-Seeking						
No	1.00			1.00		
Yes	6.52	1.19 – 35.64	0.02	6.54	1.15 – 37.03	0.02
FEMALES						
VARIABLE	Preliminary models (n=236)			Final multivariable model (n=236)		
	OR	95% C.I.	p-value	OR	95% C.I.	p-value
Parental Social Class						
Non-Manual	1.00			1.00		
Manual	2.24	0.90 – 5.50	0.08	2.16	0.80 – 5.85	0.13
Rating of Health						
Excellent/ Very Good	0.11	0.02 – 0.57		0.15	0.03 – 0.80	
Good	0.72	0.26 – 1.99		0.81	0.27 – 2.44	
Fair/ Poor	1.00		0.004	1.00		0.03
Current Problems						
No	1.00			1.00		
Yes	5.60	1.24 – 25.20	0.007	3.32	0.68 – 16.23	0.10
Suicidal Thoughts						
No	1.00			1.00		
Yes	2.80	1.04 – 7.53	0.04	1.73	0.60 – 4.96	0.31
Past Help-Seeking						
No	1.00			1.00		
Yes	4.59	1.28 – 16.43	0.07	4.13	1.04 – 16.38	0.02

Help-seeking from friends and family

As in other analyses, logistic regression analysis of the factors associated with help-seeking from friends and family in males and females were conducted controlling for GHQ score. There was less evidence of a gender interaction with GHQ in relation to help-seeking (p=0.18). After controlling for GHQ score the same factors were associated with help-seeking from friends and family in males and females (Table 5.21). These were: believing that they were currently suffering from a psychological or emotional problem (ORs 7.7 males, 4.0 females), and having sought help (from any source) in the past for psychological or emotional difficulties (ORs 7.6 males, 5.8 females). Both factors were strongly related to help-seeking and in later multivariable models (Table 5.22) there was no evidence in males or females that associations with either variable were attenuated when controlling for the other. As in previous analyses, socio-demographic factors did not appear related to be strongly related to the likelihood of help-seeking from friends and family in either sex, but neither did the existence of suicidal thoughts or poor ratings of general or 'usual' psychological health.

Table 5.21: Odds ratios (adjusted for GHQ score) of factors associated with help-seeking from friends and family in the last four weeks by male and female GHQ cases

VARIABLE	MALE (n=168-174) ⁱ			FEMALE (n=264-270) ⁱ		
	OR	95% C.I.	p	OR	95% C.I.	p
Age						
16-19 years	1.00			1.00		
20-24 years	1.24	0.56 – 2.79	0.59	0.75	0.44 – 1.28	0.29
Residency						
Parents	1.00			1.00		
Spouse/ partner	0.29	0.03 – 2.41		0.94	0.43 – 2.04	
Friends	1.89	0.74 – 4.81		1.06	0.48 – 2.34	
Other ⁱⁱ	1.41	0.36 – 5.50	0.22	1.29	0.54 – 3.05	0.94
Occupation						
Employed (ft/pt)	1.00			1.00		
Study (ft/pt)	0.69	0.29 – 1.69		1.01	0.56 – 1.81	
Other ⁱⁱⁱ	0.37	0.09 – 1.46	0.32	1.45	0.66 – 3.19	0.60
Parental Social Class^{iv}						
Non-manual	1.00			1.00		
Manual	0.59	0.22 – 1.61	0.29	0.98	0.55 – 1.74	0.94
Townsend Score						
< 0 (affluent areas)	1.00			1.00		
≥ 0 (poor areas)	0.82	0.34 – 1.98	0.66	1.32	0.78 – 2.25	0.30
Social Support						
Confidant Score						
5-9	0.48	0.07 – 3.44		0.57	0.17 – 1.89	
10-14	0.34	0.09 – 1.32		0.81	0.40 – 1.61	
15-19	1.09	0.39 – 3.03		0.66	0.34 – 1.25	
20-25	1.00		0.21	1.00		0.55
Affective Score						
3-5	0.59	0.09 – 3.62		0.58	0.18 – 1.87	
6-8	0.92	0.28 – 2.98		0.66	0.31 – 1.43	
9-11	1.42	0.57 – 3.58		1.16	0.60 – 2.24	
12-15	1.00		0.74	1.00		0.47
Rating of Health						
Excellent/ Very good	0.81	0.28 – 2.32		0.60	0.28 – 1.27	
Good	1.07	0.39 – 2.97		1.00	0.49 – 2.04	
Fair/ poor	1.00		0.83	1.00		0.19
Rating of Usual Psychological Health						
Good	1.00			1.00		
Okay	0.53	0.19 – 1.51		1.48	0.76 – 2.89	
Poor/ very poor	1.23	0.40 – 3.73	0.23	1.00	0.41 – 2.39	0.35
Current Problems						
No	1.00			1.00		
Yes	7.75	2.13 – 28.22	<0.001	3.96	2.11 – 7.45	<0.0001
Suicidal Thoughts						
No	1.00			1.00		
Yes	1.25	0.53 – 2.93	0.60	0.93	0.50 – 1.72	0.81
Past Help-Seeking						
No, have not needed to	1.00			1.00		
Yes	7.61	2.99 – 19.39	<0.0001	5.80	2.99 – 11.26	<0.0001

ⁱ The sample size varies slightly for each variable due to missing data on some items.

ⁱⁱ Includes those living alone, single parents and a small number of miscellaneous responses.

ⁱⁱⁱ Includes unemployed, looking after home/ family and not working due to sickness/ disability.

^{iv} Missing data on this variable gave a total of 155 in males and 244 in females.

Table 5.22: Help-seeking from friends and family: preliminary and final multivariable analysis of factors associated with GHQ cases’ help-seeking in the last four weeks adjusted for GHQ score

MALES						
VARIABLE	Preliminary models (n=167)			Multivariable model (n=167)		
	OR	95% C.I.	p-value	OR	95% C.I.	p-value
Current Problems						
No	1.00			1.00		
Yes	8.08	2.22 – 29.46	<0.001	6.63	1.75 – 25.04	0.002
Past Help-Seeking						
No	1.00			1.00		
Yes	6.61	2.56 – 17.08	<0.0001	5.70	2.15 – 15.12	0.0002
FEMALES						
VARIABLE	Preliminary models (n=264)			Multivariable model (n=264)		
	OR	95% C.I.	p-value	OR	95% C.I.	p-value
Current Problems						
No	1.00			1.00		
Yes	3.96	2.11 – 7.45	<0.0001	3.30	1.71 – 6.37	0.0002
Past Help-Seeking						
No	1.00			1.00		
Yes	5.60	2.88 – 10.88	<0.0001	4.88	2.47 – 9.63	<0.0001

Help-seeking in respondents with suicidal thoughts

Separate analyses were also conducted with 172 (13.6%) respondents reporting suicidal thoughts of whom 170 also indicated whether or not they had sought help. Respondents scoring on the item deemed to indicate the strongest suicidal thoughts (‘have you recently found the idea of taking your own life kept coming into your head?’) were also considered as a specific subgroup (n=137, 10.8%, of whom 135 provided data about help-seeking). The characteristics of those reporting any suicidal thoughts and those with thoughts about taking their own life are essentially the same (Tables 5.23 & 5.24) and also similar to the characteristics of GHQ cases (Table 5.6).

Compared to those who did not report suicidal thoughts, those with suicidal thoughts (hereafter, ‘suicide cases’) reported lower levels of social support and had mean social support scores lower than those of GHQ cases. They were more likely to be unemployed than those without suicidal thoughts and less likely to work fulltime. Higher proportions gave their general and usual psychological health a poor rating, and they were more likely to be using medication for psychological/ emotional problems, and to have done so in the past.

Approximately three quarters of suicide cases (73.3% any suicidal thoughts, 75.2% thoughts of taking their own life) thought that they were currently suffering from

psychological or emotional problems compared to less than a quarter of non-cases. The corresponding proportion of GHQ cases thinking they had such a problem was 56.6% (Table 5.6) demonstrating a greater perception of distress amongst those who experienced suicidal thoughts. Although the mean GHQ score of GHQ cases and suicide cases was the same, 26.2% of those with any suicidal thoughts and 29.9% of those with thoughts of taking their own life had a GHQ score of 10-12 compared to just 14.5% of GHQ cases. In total, 81% of suicide cases were also GHQ cases ($p < 0.001$). The difference in severity between suicide cases and GHQ cases is also indicated by suicide cases' usage of medication and ratings of health. Suicide cases were more likely than non-cases to be seeking help for a psychological/ emotional problem or to have done so in the past. They also reported more consultations with their GP over the past year for any reason.

As with GHQ cases, Townsend score, parental social class, and residency showed little association with suicidal thoughts. In contrast to the patterns found amongst GHQ cases, there were no gender differences amongst those reporting suicidal thoughts and suicide cases were younger. Those reporting any suicidal thoughts had a mean age of 19.1 years compared to 19.7 years in non-cases (difference=0.6, 95%CI 0.2 to 1.0, $p = 0.002$).

Table 5.23: Characteristics of respondents reporting suicidal thoughts

VARIABLE ⁱ	CASES (n=172)		NON-CASES (n=1089)		TEST	
	Mean	SD	Mean	SD	t/z ⁱⁱ	p
Age (n=1249)	19.11	2.38	19.72	2.34	3.15	0.002
Townsend Score (n=1247)	-0.13	3.24	-0.51	3.08	-1.48	0.14
Social Support						
Confidant score (n=1240)	15.6	4.94	20.27	4.23	11.05	<0.0001
Affective Score (n=1248)	9.99	3.35	12.76	2.54	10.52	<0.0001
GHQ Score (n=1261)	6.63	3.35	2.40	2.69	-14.24	<0.0001
	N (%)		N %		χ^2	P
Gender (n=1261)						
Male	81 (47.1)		471 (43.2)		0.89	0.34
Female	91 (52.9)		618 (56.7)			
Social Class (n=1166)						
Non-manual	88 (60.3)		659 (64.6)		1.04	0.31
Manual	58 (39.7)		361 (35.4)			
Residencyⁱⁱⁱ (n=1258)						
With parents	120 (70.2)		777 (71.5)		0.12	0.73
With friends	23 (13.4)		175 (16.1)		0.78	0.38
With spouse/ partner	17 (9.9)		139 (12.8)		1.10	0.29
Alone	7 (4.1)		31 (2.8)		0.78	0.38
Occupationⁱⁱⁱ (n=1257)						
Work full-time	54 (31.4)		448 (41.3)		6.06	0.01
Study full-time	73 (42.4)		506 (46.6)		1.05	0.30
Unemployed	27 (15.7)		50 (4.6)		31.75	<0.001
Home/ family	11 (6.4)		42 (3.9)		2.34	0.13
GHQ caseness (n=1261)	140 (81.4)		304 (27.9)		186.22	<0.001
GHQ bands (n=1261)						
4-6	55 (32.0)		193 (17.7)			
7-9	40 (23.3)		91 (8.4)		283.18	<0.001
10-12	45 (26.2)		20 (1.8)			
Psychological medicine-taking (n=1252)						
Currently	37 (21.9)		36 (3.3)		91.81	<0.001
In past	53 (31.2)		109 (10.1)		58.08	<0.001
Rating of general health^{iv} (n=1257)						
Excellent/ very good	53 (30.8)		605 (55.8)		64.71	<0.001
Good	71 (41.3)		382 (35.2)			
Fair/ poor	48 (27.9)		98 (9.0)			
'Usual' psychological health^{iv} (n=1257)						
Good	26 (15.1)		621 (57.2)			
Okay	75 (43.6)		415 (38.2)		268.65	<0.001
Poor	57 (33.1)		45 (4.1)			
Very poor	14 (8.1)		4 (0.4)			
Self-rated current problems (n=1247)	126 (73.3)		224 (20.8)		201.80	<0.001
GP consultations (last yr) (n=1259)						
None	21 (12.2)		227 (20.9)			
1-2	63 (36.6)		530 (48.8)		50.00	<0.001
3-4	41 (23.8)		226 (20.8)			
5 plus	47 (27.3)		104 (9.6)			
Help-seeking (psychological)						
Any recent (n=1253)	62 (36.5)		138 (12.7)		61.67	<0.001
Any past (n=1257)	96 (56.5)		403 (37.1)		23.10	<0.001
Ever not sought help (n=1225)	106 (63.5)		251 (23.7)		110.36	<0.001

ⁱ Suicidal thoughts could be measured in 1261 respondents. Missing data on other items means the total n for some variables is slightly lower.

ⁱⁱ Unpaired t-test used for age and Wilcoxon rank-sum (Mann-Whitney) test used for social support and GHQ score. Non-parametric testing was selected to allow for the skewness of the latter distributions.

ⁱⁱⁱ Percentages do sum to 100% so not all responses categories are summarised and the options given were not mutually exclusive so some respondents may have selected more than one category.

^{iv} Self-rated.

Table 5.24: Characteristics of respondents reporting recent thoughts of 'taking their own life'

VARIABLE ⁱ	CASES (n=136)		NON-CASES (n=1125)		TEST	
	Mean	SD	Mean	SD	t/z ⁱⁱ	p
Age (n=1249)	19.15	2.48	19.69	2.33	-2.53	0.01
Townsend Score (n=1247)	-0.12	3.16	-0.49	3.10	1.33	0.18
Social Support						
Confidant score (n=1240)	15.12	4.79	20.18	4.29	10.74	<0.0001
Affective Score (n=1248)	9.72	3.27	12.70	2.59	10.27	<0.0001
GHQ Score (n=1261)	6.71	3.48	2.53	2.78	-12.34	<0.0001
	N (%)		N (%)		χ^2	p
Gender (n=1261)						
Male	61 (44.5)		492 (43.7)		0.04	0.85
Female	76 (55.5)		635 (56.3)			
Social Class (n=1166)						
Non-manual	70 (59.8)		679 (64.5)		1.02	0.31
Manual	47 (40.2)		373 (35.5)			
Residencyⁱⁱⁱ (n=1258)						
With parents	93 (68.4)		807 (71.7)		0.67	0.41
With friends	19 (14.0)		179 (15.9)		0.34	0.56
With spouse/ partner	13 (9.6)		143 (12.7)		1.11	0.29
Alone	7 (5.1)		31 (2.8)		2.37	0.12
Occupationⁱⁱⁱ (n=1257)						
Work full-time	43 (31.4)		460 (41.0)		4.67	0.03
Study full-time	54 (39.4)		527 (46.9)		2.77	0.10
Unemployed	24 (17.5)		53 (4.7)		34.86	<0.001
Home/ family	10 (7.3)		43 (3.8)		3.65	0.06
GHQ caseness (n=1261)	111 (81.0)		336 (29.8)		140.13	<0.001
GHQ bands (n=1261)						
4-6	41 (29.9)		208 (18.5)			
7-9	29 (21.2)		104 (9.2)		257.81	<0.001
10-12	41 (29.9)		24 (2.1)			
Psychological medicine-taking (n=1252)						
Currently	32 (23.9)		41 (3.7)		89.35	<0.001
In past	46 (33.8)		116 (10.4)		59.35	<0.001
Rating of general health^{iv} (n=1257)						
Excellent/ very good	38 (27.7)		622 (55.4)		74.45	<0.001
Good	55 (40.1)		399 (35.5)			
Fair/ poor	44 (32.1)		102 (9.1)			
'Usual' psychological health^{iv} (n=1257)						
Good	17 (12.4)		631 (56.2)			
Okay	59 (43.1)		433 (38.6)		253.87	<0.001
Poor	48 (35.0)		54 (4.8)			
Very poor	13 (9.5)		5 (0.4)			
Self-rated current problems (n=1247)	103 (75.2)		34 (24.8)		169.68	<0.001
GP consultations (last yr) (n=1259)						
None	15 (10.9)		234 (20.8)			
1-2	46 (33.6)		548 (48.7)		49.34	<0.001
3-4	37 (27.0)		231 (20.5)			
5 plus	39 (28.5)		112 (10.0)			
Help-seeking (psychological)						
Any recent (n=1253)	50 (37.0)		150 (13.4)		50.36	<0.001
Any past (n=1257)	81 (59.6)		419 (37.3)		25.16	<0.001
Ever not sought help (n=1225)	93 (69.4)		265 (24.2)		117.98	<0.001

ⁱ 137 respondents reported recent thoughts of taking their own life. Missing data means that the total 'n' for some variables is slightly lower.

ⁱⁱ Unpaired t-test used for 'age' and Wilcoxon rank-sum (Mann-Whitney) test used for 'Social Support Scores', 'GHQ score' and 'Suicide ideation score'. Non-parametric testing was selected to allow for the skewness of the latter distributions.

ⁱⁱⁱ Percentages do not sum to 100% as not all response categories are summarised and the options were not mutually exclusive so some respondents may have selected more than one category.

^{iv} Self-rated.

The prevalence of help-seeking

The prevalence of help-seeking for psychological/emotional problems amongst those with any suicidal thoughts was 36.5% and only marginally higher - 37.3% - amongst those reporting thoughts of taking their own life (Table 5.25). A greater proportion of 'suicide cases' therefore had sought help than GHQ cases (29.7%) (Table 5.7). This increased prevalence related to a greater use of formal help sources by 'suicide cases' than GHQ cases, though still use of these was notably low. For instance, a GP had been consulted in the last four weeks by 14.7% of those with any suicidal thoughts and 14.2% of those with thoughts about taking their own life compared to just 8.3% of GHQ cases. Help-seeking from friends and family, however, was roughly the same in 'suicide' and GHQ-cases. These patterns are consistent with the observation that those with suicidal thoughts tended to have higher GHQ scores and that friends and family deal with less severe distress while GP help is sought by those with a higher level of severity (above).

Table 5.25: The prevalence of help-seeking and use of specific help-sources by those with any suicidal thoughts and thoughts of taking their own life in the last 4 weeks

HELP SOURCE	ALL N (%) ⁱ	MALE N (%) ⁱ	FEMALE N (%) ⁱ	p
Responders with suicidal thoughts (male=81, female=89)				
Any help	62 (36.5)	25 (30.9)	37 (41.6)	0.15
GP	25 (14.7)	10 (12.3)	15 (16.8)	0.41
Counsellor	9 (5.3)	3 (3.7)	6 (6.7)	0.38
Psychiatrist	5 (2.9)	3 (3.7)	2 (2.2)	0.57
Family	26 (15.3)	11 (13.6)	15 (16.8)	0.55
Friend	39 (22.9)	14 (17.3)	25 (28.1)	0.09
Samaritans	1 (0.6)	-	1 (1.1)	0.34
Other telephone line	1 (0.6)	1 (1.2)	-	0.29
Self-help/ voluntary sector group	3 (1.8)	1 (1.2)	2 (2.2)	1.00
Teacher/ Employer	5 (2.9)	2 (2.5)	3 (3.4)	0.73
Other	9 (5.3)	4 (4.9)	5 (5.6)	0.90
Responders with thoughts of taking their own life (male=61, female=74)				
Any help	50 (37.3)	21 (34.4)	29 (39.7)	0.53
GP	19 (14.2)	8 (13.1)	11 (15.1)	0.75
Counsellor	8 (6.0)	3 (4.9)	5 (6.8)	0.64
Psychiatrist	4 (3.0)	2 (3.3)	2 (2.7)	0.85
Family	22 (16.4)	9 (14.7)	13 (17.8)	0.63
Friend	32 (23.9)	12 (19.7)	20 (27.4)	0.30
Samaritans	1 (0.7)	-	1 (1.4)	0.36
Other telephone line	1 (0.7)	1 (1.6)	-	0.27
Self-help/ voluntary sector group	0	-	-	-
Teacher/ Employer	3 (2.2)	1 (1.6)	2 (2.7)	0.67
Other	9 (6.7)	4 (6.6)	5 (6.8)	1.00

ⁱ Percentages for use of specific sources exceed those of total help-seeking as some cases sought help from more than one source.

In contrast to patterns found amongst GHQ cases (Table 5.7), there was only weak evidence for sex differences in the prevalence of help-seeking amongst suicide cases, but some indication where the group with any suicidal thoughts was considered, that females sought more help overall and from friends. The evidence was particularly weak where only those responders reporting thoughts of taking their own life were considered suggesting that this too may be explained by severity, gender becoming less important when higher levels of severity are reached.

Factors associated with help-seeking

Due to the small numbers of respondents reporting suicidal thoughts and seeking help, analyses of the factors associated with help-seeking from a GP (Table 5.26) and from friends and family (Table 5.27) were limited to comparisons of mean scores (t-test) and proportions (chi-squared test) in help-seeking and non-help-seeking cases. However, a regression model was used to explore factors associated with any recent help-seeking (Table 5.28). The analyses described below relate to respondents with any suicidal thoughts. These were repeated for the subgroup reporting thoughts of taking their own life but the results are not tabulated since they show essentially the same patterns and are more restricted, relating to an even smaller number of cases.

Help-seeking from a GP and from friends and family

In keeping with GHQ cases, GHQ score (severity) was a strong predictor of help-seeking amongst those with suicidal thoughts and was most important to help-seeking from a GP but less important in relation to whether help was sought from friends and family. This is represented by the difference in mean GHQ scores between help-seekers and non-help-seekers. The mean GHQ score of those with suicidal thoughts who sought help from a GP was 9.0 compared to 6.2 in non-help-seekers with suicidal thoughts (difference= 2.8, 95%CI 1.4 to 4.2, $p=0.0001$, Table 5.26). The corresponding mean score amongst those seeking help from friends and family were 7.5 in help-seekers and 6.2 in non-help-seekers (difference=1.3, 95%CI 0.2 to 2.4, $p=0.02$, Table 5.27). This indicates that help-seeking from a GP tends not to occur until a high threshold of severity has been reached or exceeded but that help may be sought from friends or family when morbidity is less extreme.

Also in keeping with GHQ cases, help-seeking suicide cases reported more past help-seeking for psychological/emotional problems, gave a low rating of their general health and were more likely to think they were currently suffering from psychological/emotional problems – though there was only weak evidence for the latter when considering GP help-seeking. Poor usual psychological health was associated with help-seeking from a GP but less with help-seeking from friends and family.

Socio-demographic factors did not generally predict help-seeking amongst those with suicidal thoughts, although more GP help-seekers (28% versus 13.8% non-help-seekers, $p=0.07$) (Table 5.26) were unemployed and an association was found between Townsend score and help-seeking from friends and family – those who sought help living in poorer areas than those who did not (difference in mean scores=1.3, 95%CI 0.22 to 2.36, $p=0.02$) (Table 5.27). Gender showed only very weak association – even where lay group help was considered, which is in clear contrast to patterns found amongst GHQ cases. Since those with suicidal ideation were a group with more severe morbidity (above), this finding may suggest that sex differences become less important where distress is severe which would also reinforce the notion that one of the key differences between the help-seeking of distressed young males and females is the threshold at which they seek help – females being more likely to seek help with less extreme morbidity.

Regression analysis – any help-seeking

Table 5.28 shows a regression analysis of factors associated with any help-seeking by those with suicide thoughts. Since GHQ score remained an important predictor of help-seeking amongst those with suicidal thoughts, this was again controlled for to identify the independent effects of other variables and the Table shows odds ratios before and after making this adjustment. These results confirm the patterns described above. The main predictors of recent help-seeking after controlling for GHQ score amongst responders with suicidal thoughts were: past help-seeking for a psychological/emotional problem; perception of current psychological/emotional problems; and low self-rated general health. There was also some evidence that those with low social support and living in less deprived areas were less likely to seek some form of help. The model emphasised a lack of relationship between gender and help-seeking in those with suicidal thoughts.

Table 5.26: Characteristics associated with help-seeking from a GP in respondents with suicidal thoughts

VARIABLE ⁱ	HELP-SEEKERS (N=25)		NON-HELP-SEEKERS (N=145)		TEST	
	Mean	SD	Mean	SD	t/z ⁱⁱ	p
Age	19.56	2.24	19.02	2.39	1.04	0.30
Townsend score	0.35	0.26	-0.18	0.79	0.76	0.45
Social Support						
Confidant	16.17	4.05	15.48	5.10	0.66	0.51
Affective	10.33	3.18	9.94	3.40	0.49	0.62
GHQ score	9.00	3.19	6.20	3.21	4.03	<0.001
	N (%)		N (%)		χ^2	p
Gender						
Male	10 (40.0)		71 (49.0)		0.69	0.41
Female	15 (60.0)		74 (51.0)			
Social class						
Non-manual	12 (54.5)		75 (61.0)		0.32	0.57
Manual	10 (45.4)		48 (39.0)			
Residency ⁱⁱⁱ						
With parents	16 (64.0)		102 (70.8)		0.47	0.49
With friends	4 (16.0)		19 (13.2)		0.14	0.71
With spouse/ partner	1 (4.0)		16 (11.1)		1.19	0.27
Alone	2 (8.0)		5 (3.5)		1.09	0.29
Occupation ⁱⁱⁱ						
Work full-time	6 (24.0)		47 (32.4)		0.70	0.40
Study full-time	7 (28.0)		65 (44.8)		2.47	0.11
Unemployed	7 (28.0)		20 (13.8)		3.22	0.07
Home/ family	3 (12.0)		8 (5.5)		1.48	0.22
Rating of general health ^{iv}						
Excellent/ Very good	3 (12.0)		50 (34.5)		5.41	0.07
Good	12 (48.0)		58 (40.0)			
Fair/ poor	10 (40.0)		37 (25.5)			
GHQ bands						
Non-case	2 (8.0)		30 (20.6)			
4-6	2 (8.0)		52 (35.9)		17.56	0.001
7-9	7 (28.0)		33 (22.8)			
10-12	14 (56.0)		30 (20.7)			
Usual Psychological Health ^{iv}						
Good	2 (8.0)		23 (15.9)			
Okay	7 (28.0)		67 (46.2)		11.73	0.008
Poor	10 (40.0)		47 (32.4)			
Very poor	6 (24.0)		8 (5.5)			
Self-rated current problems	22 (88.0)		102 (70.3)		3.37	0.07
Past help-seeking	20 (80.0)		76 (53.1)		7.08	0.01

ⁱ The total n for each question varies slightly due to missing data on some items – range: 24-25 (help-seekers), 140-145 (non-help-seekers) except social class where n=22 (help-seekers) & 123 (non-help-seekers).
ⁱⁱ Unpaired t-test used for age and Wilcoxon rank-sum (Mann-Whitney) test used for social support and GHQ score. Non-parametric testing was selected to allow for skewness of the latter distributions.
ⁱⁱⁱ Percentages do not sum to 100% as not all response categories are summarised and the options are not mutually exclusive so some respondents may have selected more than one category.
^{iv} Self-rated.

Table 5.27: Characteristics associated with help-seeking from friends and family in respondents with suicidal thoughts

VARIABLE ⁱ	HELP-SEEKERS (N=49)		NON-HELP-SEEKERS (N=121)		TEST	
	Mean	SD	Mean	SD	t/z ⁱⁱ	p
Age (n=49, 120)	19.00	2.19	19.15	2.44	-0.37	0.71
Townsend score (n=49, 120)	0.82	0.47	-0.48	0.29	2.39	0.02
Social Support						
Confidant (n=47, 117)	15.28	4.56	15.70	5.11	-0.59	0.56
Affective (n=48, 120)	10.12	2.96	9.95	3.52	0.11	0.91
GHQ score	7.51	3.29	6.25	3.31	2.30	0.02
	N (%)		N (%)		χ^2	p
Gender						
Male	20 (40.8)		61 (50.4)		1.29	0.26
Female	29 (59.2)		60 (49.6)			
Social class						
Non-manual	25 (62.5)		62 (59.1)		0.14	0.70
Manual	15 (37.5)		43 (40.9)			
Residency ⁱⁱⁱ						
With Parents	29 (60.4)		89 (73.5)		2.81	0.09
With Friends	8 (16.7)		15 (12.4)		0.53	0.46
With Spouse/ partner	5 (10.4)		12 (9.9)		0.01	0.92
Alone	1 (2.1)		6 (5.0)		0.72	0.40
Occupation ⁱⁱⁱ						
Work Full-time	13 (26.5)		40 (33.1)		0.69	0.40
Study Full-time	20 (40.8)		52 (43.0)		0.07	0.80
Unemployed	9 (18.4)		18 (14.9)		0.32	0.57
Home/ Family	5 (10.2)		6 (5.0)		1.59	0.21
Rating of general health ^{iv}						
Excellent/ Very Good	9 (18.4)		44 (36.4)		5.41	0.07
Good	23 (46.9)		47 (38.8)			
Fair/ Poor	17 (34.7)		30 (24.8)			
GHQ bands						
Non-case	7 (14.3)		25 (20.7)			
4-6	13 (26.5)		41 (33.9)		6.05	0.11
7-9	10 (20.4)		30 (24.8)			
10-12	19 (38.8)		25 (20.7)			
Usual Psychological Health ^{iv}						
Good	5 (10.2)		20 (16.5)			
Okay	21 (42.9)		53 (43.8)		4.03	0.26
Poor	16 (32.6)		41 (33.9)			
Very Poor	7 (14.3)		7 (5.8)			
Self-rated current problems	45 (91.8)		79 (65.3)		12.45	<0.001
Past help-seeking	38 (77.5)		58 (48.7)		11.76	0.001

ⁱ The total n for each question varies slightly due to missing data on some items – range: 47-49 (help-seekers), 117-121 (non-help-seekers), except social class where n=40 (help-seekers) & 105 (non-help-seekers).

ⁱⁱ Unpaired t-test used for age and Wilcoxon rank-sum (Mann-Whitney) test used for social support and GHQ score. Non-parametric testing was selected to allow for the skewness of the latter distributions.

ⁱⁱⁱ Percentages do not sum to 100% as not all response categories are summarised and the options given were not mutually exclusive so some respondents may have selected more than one category.

^{iv} Self-rated: ‘In general, how would you rate your health?’

Table 5.28: Odds ratios (unadjusted and adjusted for GHQ score) of factors associated with any recent help-seeking in respondents with suicidal thoughts

VARIABLE ⁱ	Unadjusted Odds Ratios		Adjusted for GHQ Score		
	OR	95% C.I.	OR	95% C.I.	p
Age					
16-19 years	1.00				
20-24 years	1.11	0.59 – 2.06	1.02	0.52 – 1.98	0.96
Gender					
Male	1.00		1.00		
Female	1.60	0.87 – 2.96	1.11	0.57 – 2.17	0.75
Parental social class					
Non-manual	1.00		1.00		
Manual	0.96	0.49 – 1.86	1.00	0.49 – 2.02	0.99
Townsend score					
Less than 0	1.00		1.00		
More than 0	1.63	0.88 – 3.01	1.83	0.95 – 3.52	0.07
Residency					
Parents	1.00		1.00		
Spouse/ Partner	1.23	0.37 – 4.07	1.32	0.37 – 4.68	
Friends	1.43	0.52 – 3.91	1.35	0.47 – 3.91	
Alone	1.97	0.36 – 10.31	1.50	0.24 – 9.16	
Other ⁱⁱ	4.59	1.11 – 18.96	4.38	1.00 – 19.26	0.36
Occupation					
Employed (ft)	1.00		1.00		
Study (ft)	0.89	0.35 – 2.25	0.76	0.28 – 2.02	
Employed/ Study (pt)	1.22	0.47 – 3.17	1.29	0.47 – 3.52	
Unemployed	2.90	0.97 – 8.63	2.15	0.67 – 6.96	
House and/ or Family	0.39	0.04 – 3.62	0.28	0.03 – 2.83	
Other ⁱⁱⁱ	5.80	0.55 – 60.67	3.59	0.31 – 40.79	0.29
Social Support					
Confidant Score					
5-9	0.65	0.16 – 2.56	0.33	0.07 – 1.49	
10-14	1.36	0.50 – 3.65	1.13	0.39 – 3.31	
15-19	1.77	0.66 – 4.74	2.00	0.68 – 5.85	
20-25	1.00		1.00		0.06
Affective Score					
3-5	1.09	0.36 – 3.33	0.74	0.22 – 2.48	
6-8	0.66	0.26 – 1.68	0.59	0.22 – 1.59	
9-11	1.72	0.73 – 4.07	1.88	0.75 – 4.75	
12-15	1.00		1.00		0.14
Rating of Health					
Excellent/ very good	1.00		1.00		
Good	2.94	1.32 – 6.53	3.12	1.33 – 7.31	
Fair/ Poor	4.18	1.75 – 9.98	3.26	1.29 – 8.24	0.01
Rating of Usual Psychological Health					
Good	1.00		1.00		
Okay	2.13	0.72 – 6.25	1.72	0.56 – 5.25	
Poor/ very poor	3.99	1.36 – 11.69	2.23	0.71 – 7.03	0.37
Current problems					
No	1.00		1.00		
Yes	10.35	3.52 – 30.44	7.15	2.33 – 21.90	0.0001
Past Help-Seeking					
No	1.00		1.00		
Yes	7.21	3.41 – 15.21	7.29	3.28 – 16.19	<0.0001

ⁱ Missing data on some items means the total n for some variables is slightly lower: range 164-170, except social class where n=158.

ⁱⁱ Other includes those living with grandparents, single parents living with their own children, those living in work staff accommodation and a small number of other miscellaneous responses provided by respondents.

ⁱⁱⁱ Includes those unable to work due to disability or ill health.

Summary

This chapter has reported findings from a cross-sectional survey of young adults. The main findings can be summarised as follows:

- 35.4% of respondents were GHQ cases (score ≥ 4) and 13.6% reported suicidal thoughts.
- Less than 30% of GHQ cases had sought help.
- Friends were the most popular source of help, while only 8.3% of those with probable mental disorder had recently consulted a GP about mental distress.
- The prevalence of help-seeking was only slightly higher amongst those reporting suicidal thoughts (36.5%). Less than 15% had consulted a GP and only one had recently contacted the Samaritans.
- Severity of distress (GHQ score) was the main factor associated with help-seeking amongst GHQ cases. This association was strongest for GP help-seeking but less marked where friends and family were the source.
- A perception of currently suffering from psychological/ emotional problems and having sought help in the past were also important factors.
- Additional morbidity factors (self-rated general and psychological health and suicidal thoughts) showed association with help-seeking from a GP but only a weak relationship with help-seeking from friends and family.
- More female cases sought help than males. This was accounted for by their greater use of friends and family as a source of help. Approximately the same proportion of male and female cases had consulted a GP.
- Severity was a stronger predictor of help-seeking in males than females. Male GHQ cases had a higher threshold of severity for help-seeking than females, particularly in relation to seeking help from a GP.

These findings are discussed further in chapter 8. The next chapters (6&7) report findings from the qualitative interviews.

CHAPTER 6: YOUNG ADULTS' CONCEPTIONS OF MENTAL ILLNESS AND HELP-SEEKING BEHAVIOUR

Introduction

The previous chapter described results from the quantitative component of this study and noted that only a small proportion of GHQ cases had sought help for their distress. This and the next chapter turn to the qualitative data. The chapter begins with a description of those interviewed and an overview of their general beliefs about mental distress and help-seeking, thus describing the framework and context within which episodes of mental distress were experienced and help-seeking decisions made. The chapter then focuses in depth on interviewees' narratives of experiencing and responding to their own episodes of mental distress and the rationales informing their help-seeking behaviour.

Characteristics of interviewees

In total, 106 survey responders were sent interview recruitment letters and 29 agreed to be interviewed. Six could not be contacted or did not attend so 23 interviews were completed. Individuals were sampled purposively to recruit males and females across the age range with a variety of illness behaviours, range of GHQ scores and spread of socio-demographic characteristics. Interviewing occurred in batches until a diverse group had been interviewed and consistent data were emerging with each interview (n=23).

Interviewees' socio-demographic characteristics are summarised in Table 6.1. Slightly more females than males were interviewed. In keeping with the survey population characteristics (Chapter 5), most interviewees lived with their parents and more were from non-manual class backgrounds, though those with other living arrangements and from manual class backgrounds were also interviewed. The mean age (19.6 years) and Townsend score (-0.6) of those interviewed were very similar to that of the survey population. Social support scores were lower but a range was represented.

Table 6.1: Socio-demographic characteristics of interview responders

CHARACTERISTIC	N
Gender	
Male	10
Female	13
Parental social class	
Non manual	16
Manual	6
Not reported	1
Residency	
Parents	17
Friends	3
Spouse or partner	3
Alone	2
Occupation	
Work full/part-time	10
Study full/ part-time	12
Unemployed	3
House and family	1
	Mean (range)
Age (yrs)	19.6 (16-24)
Townsend Score	-0.6 (-4.8 to 4.9)
Social Support	
Confidant score	13.6 (6 to 24)
Affective score	9.9 (4 to 15)

The morbidity and help-seeking characteristics of interviewees are shown in Tables 6.2 (males) and 6.3 (females). These also provide a brief summary of the illness and help-seeking narratives of each interviewee. At the time of the survey, 14 interviewees reported suicidal thoughts, 8 were taking medication for mental distress and 21 were GHQ cases (mean GHQ score=8.2). The two ‘non-GHQ-cases’ were a past case (*i.d.* 2) and a chronic case currently receiving treatment (*i.d.* 14). It appeared two interviewees (*i.d.* 6 & 8) had been misclassified by the survey GHQ screening as they did not have personal narratives of distress to recount although they did explain the high score by transient ‘stress’. In these interviews, general beliefs about mental distress and help-seeking were sought. The remainder had experienced varying levels of mental distress either currently or in the past as indicated by their GHQ, CIS-R scores and narratives of distress.

Table 6.2: Morbidity and help-seeking characteristics of male interviewees

ID	Age	GHQ (1)	GHQ (2)	CIS-R score	Narrative of distress	Help-seeking narrative
1	20yrs	10*	Not completed		Possible past case: series of life-events lead to him feeling 'down', hopeless, and worthless. Feelings had improved but recur periodically.	Considered speaking to a friend or attending a counsellor but in the end did not seek any help.
4	21yrs	10*	Not completed		Possible past case: described symptoms of depression lasting for 2-3months	Did not seek any help until confiding in friends and family when they confronted him having noticed a change in him.
6	17yrs	7	0	2	Non-case: Reported no symptoms (ever). Explained GHQ score by change of job	N/A
7	17yrs	5	1	15	Current case: described a range of on-going symptoms.	Had not sought any help and considered that he had no need to do so perceiving his symptoms as 'normal'.
8	17yrs	10*	0	4	Non-case: Reported no symptoms (ever). Explained GHQ score by difficult homework.	N/A
10	16yrs	10*	10	17	Current case: reported on-going symptoms which he attributed to GSCE stress	Referred by teacher to school counsellor due to disruptive behaviour. Attended once. No other help-seeking.
14	18yrs	0*	3	17	Current case: described episode of depression with suicidal thoughts spanning past year.	After several months, consulted GP and spoke to parents. Taking anti-depressants. Refused treatment from psychiatrist.
16	19yrs	12*	12	33	Current case: feelings of depression past 2yrs. Diagnosed (last 10 months) with anorexia and depression. 2 recent overdoses. Self-cutting.	After some time and against his will, mother took him to GP due to weight loss. After a second occasion he was referred to a psychiatrist who was treating him at the time of interview.
19	23yrs	8*	0	8	Past case: reported history of self-cutting leading to psychiatric in-patient care	No help-seeking. Self-cutting discovered at work. Occupational health alerted medical services. Admitted to hospital.
21	18yrs	12*	2	5	Current case: described on-going episode of depression. Reported 1 episode of self-cutting	After several months was persuaded to seek help from GP by girlfriend. Attending GP and taking anti-depressants.

Key:

GHQ1 at survey, * indicates suicidal thoughts were also reported.

GHQ2 at interview

Table 6.3: Morbidity and help-seeking characteristics of female interviewees

ID	Age	GHQ (1)	GHQ (2)	CIS-R score	Narrative of distress	Help-seeking narrative
2	19yrs	3	Not completed		Past case: reported that her mental health deteriorated over a period of two years culminating in 'a nervous breakdown'. No symptoms at time of interview.	Long period of non-help-seeking punctuated by several attempts to obtain help: confided in friends, called Samaritans when given number by her mother, somatic presentation to GP (not at her own practice). Eventually, parents called GP to home. Admitted to psychiatric unit.
3	20yrs	10*	Not completed		Chronic case: episodes of depression over past 5 years. Had made two suicide attempts	Long periods of non-help-seeking. After first overdose, friends took her suicide notes to her GP who contacted her and referred her to a psychiatrist. Withdrew from treatment until second suicide attempt. Seeing psychiatrist at time of interview.
5	22yrs	12*	4	-	Chronic case: history of mental health problems from age 13 – including alcohol abuse and depression	Parents took her for treatment for alcohol abuse when a young teenager. Recently consulted GP for depression on suggestion of aunt.
9	23yrs	8	2	22	Chronic case: episodes of depression over past 3 years. Persistent low mood. Some suicidal thoughts	Taken to GP by mother. Prescribed anti-depressants and referred for counselling. Stopped taking anti-depressants. Not seeking help at time of interview.
11	21yrs	9*	9	15	Current case: reported feelings of depression persisting over past few months	Confided in friends and employer after 'breaking down' at work. By time of interview, had decided to consult GP.
12	18yrs	11	4	-	Possible past case: described distress at two major life events. In past, planned an overdose.	Attended counselling in past following coercion from parents. More recently was dissuaded from seeking help by mother.
13	20yrs	7	1	6	Past case: reported history of self-cutting and past feelings of depression	Confided in boyfriend but had sought no other help.
15	18yrs	12*	12	38	Current case: severe symptoms persisting over several months and current suicidal thoughts.	Had made a few indirect attempts to confide in a teacher and friends and an unsuccessful attempt to indicate how she felt to her GP when consulting with physical complaint.
17	23yrs	7	2	9	Past case: described past feelings of depression and eating disorder. Had contemplated suicide. Current occasional feelings of distress.	Somatic presentation to GP who diagnosed 'stress' and offered anti-depressants which she refused. No other help-seeking.

Table 6.3: Morbidity and help-seeking characteristics of female interviewees (cont.)

18	18yrs	6	4	26	Current case: diagnosed with panic disorder and mild depression	Did not seek help for feelings of depression. After several months suffered panic attack. Told mother immediately and consulted GP. Using herbal remedies and awaiting counselling.
20	18yrs	6*	1	12	Possible past/ current case: Described feelings of distress and previous suicidal thoughts.	Spoke to teacher and friend. Teacher suggested she attend GP. GP referred her to counselling. No current help-seeking.
22	23yrs	5	1	9	Possible current case: Reported on-going and worsening feelings of depression	Casually confided in a friend who suggested counselling. Did not seek this but said she would like to.
23	24yrs	9*	7	24	Chronic case: described persisting episodes of depression with suicidal thoughts over past few years.	After long period of non-help-seeking consulted GP on colleague's suggestion. Refused referral to CPN/ psychiatrist. Stopped taking anti-depressants and broke contact with GP. More recently sought counselling. Currently not seeking help.

Key:

GHQ1 at survey, * indicates suicidal thoughts were also reported.

GHQ2 at interview

At interview, the GHQ was completed by 19 interviewees and the CIS-R administered to 17. Of these, 8 interviewees scored as GHQ cases and 10 as CIS-R cases (threshold score 12) indicating the presence of current significant neurotic symptoms. This gives an indication of current levels of distress, however, one interviewee being treated for mental disorder at the time of interview did not score as a CIS-R case (*i.d.* 21) and past cases were also interviewed. Of those who did not complete the CIS-R, two were receiving formal treatment (*i.d.* 3 & 5), one was a past case who had received secondary care (*i.d.* 2), one was a GHQ case who had made a past suicide attempt (*i.d.* 12), and two described past episodes of distress though neither had sought help so these were difficult to gauge (*i.d.* 1 & 4).

According to their survey responses, 10 interviewees had sought some form of help in the past 4 weeks and the same number had sought help in the past but Tables 6.2 & 6.3 illustrate the difficulties and pitfalls of attempting to assign interviewees a help-seeking status (eg. help-seeker or non-help-seeker). Help-seeking trajectories were complex, changeable and often characterised by long periods of non-help-seeking. Those who had received help had done so through varied pathways that could involve chance, choice, coercion, or a combination of these and some had not *sought* help but become recipients of it following lay intervention. Such complexity meant that it was problematic to attempt comparative analysis on the basis of a reductive help-seeking status. A cross-sectional thematic analysis is thus presented and these issues are explored in some depth.

Concepts of health, illness and mental distress

Most interviewees described primarily physical concepts of health based around behaviours such as exercising, healthy eating, and not smoking, and sometimes including disease, disability, 'germs' and immunity. A small number of interviewees saw health exclusively in these terms. In contrast, understandings of mental health were undeveloped and limited, consisting mainly of notions about 'being happy' and sometimes 'stress'.

(LB: What sorts of things would you usually associate with good health?) Not me! Are you on about physical or mental health? (LB: well both). Then not me because I smoke, I eat, I drink, I sit in the chair a lot...I don't walk to many places and my diet is very poor I must admit. I mean I work in a chip shop so on my break I have a nice portion. (LB: Okay, how about mental health?) Um,

as far as I know it's just being a happy person. If you're happy and enjoying yourself then you're more like to have a fairly good mind and not quite going potty (10: male, 16yrs).

Some assigned mental health a secondary role as a factor that contributed to overall (physical) health rather than being an aspect of health per se.

Mental is quite a serious factor as well. If you're down and out then you're just gonna be lying around not doing much at all so that's gonna make you put on weight and stuff (LB: right so it can effect your physical side?) yeah. (LB: But is it important in it's own right?) Um, I don't know, depends. If you are, you know happy in life then you're up for doing things but yeah I think it can effect the physical side quite severely but when it comes to health the physical side is taken more seriously rather than the mental side...I usually do see health as going out and exercising and I'm sure most people do as well (8: male, 17 yrs).

Others, seeing emotional disturbances as part of normal life, appeared to exclude these from the requirements for good health:

Good physical health is top of the list as far as illnesses and things like that go and fitness. Mental health does come in there as well, I don't know, if someone said are you fit and well I'd think physically more than I would mentally. (LB: Is that because you think physical health is more important than mental health?). I wouldn't say more important...it could be normal to feel a bit miserable anyway but as long as I'm physically fine then yeah I'm healthy (1: male, 20 yrs).

Two interviewees saw mental well-being as referring to something other than 'health' though could not define what.

I feel that I'm healthy...I mean they always say healthy, yeah, you've got a good heart, you eat well, and things like that but personal and mental kind of things are completely different, you can't put those in the same category as healthy, I mean I myself think I'm healthy even though I know I've got depression (LB: are they things you don't really associate with health then, depression and feelings?) I wouldn't myself, no (11: female, 21yrs).

In contrast, a small group of interviewees prioritised mental over physical well-being, though their descriptions of mental health were still limited. With one exception, these interviewees were female. They also tended to have experienced long trajectories of mental distress and attributed the priority they gave mental health to these experiences.

Good health? Feeling good, in yourself, towards others, that's it really, that's good health. (LB: so you're thinking more emotional rather than physical). Oh yeah I am aren't I? Oh well yeah being physically alright, capable of doing things. (LB: Do you think emotional health is more important?) I do actually. If you're working all upstairs alright then you can get on (5, female 22yrs).

However, several interviewees (male and female), also with significant episodes of mental distress, conceived of health primarily (*i.d.* 2,9,10,21,22) or exclusively (*i.d.* 3) in physical terms.

Concepts of mental distress

When asked about mental distress, interviewees referred to life events, stress and several mental disorders, especially, depression. They made distinctions between types of mental distress polarising these into two categories. They regarded one as illness or 'real' distress and the other as 'everyday' 'normal' experience, which they deemed as 'non-illness'. Male and female accounts did not differ.

Mental illness – 'real' distress

Interviewees conceptualised 'real' mental illness as an extreme category of severe mental disturbance. This encompassed schizophrenia, psychosis, alcohol and drug disorders, obsessions, dementia, and in some cases severe depression and suicidality.

*(LB: If I said mental illness what sorts of things does that make you think of?)
Maybe people who's got voices in their heads (laughs) (LB: so quite extreme?)
yeah, yeah, definitely, people that are paranoid. I reckon that's mental health
(22: female, 23yrs).*

'Real' mental illness was frequently regarded as 'madness' and most interviewees used stigmatising labels and behaviours to describe those fitting their definition of 'mentally ill'. These included being 'sick', 'screwy', or 'ill in the head' (*i.d.* 7, 8, 9, 10, 12), 'totally mental' (*i.d.* 12), 'gone up there' (*i.d.* 14), a 'freak', 'weird', 'potty' or 'nutty' (*i.d.* 2, 3, 8, 10, 14, 18), 'gibbering' (*i.d.* 19), a 'nutcase in a padded cell' (*i.d.* 10, 17) or 'sat rocking in a dark room' (*i.d.* 22).

Several interviewees also associated mental illness with a loss of control of oneself or one's life, an inability to cope, institutionalisation and the need for treatments such as ECT.

People with psychiatric illness generally can't control themselves that well, either the way they act or the way they behave or their actual physical features... People with psychiatric problems are people who generally can't hack it almost. Their minds generally kind of break down and go through certain problems that drugs can overcome sometimes or, I don't know what they do in those places, electric shocks (10: male, 16yrs).

This extreme conceptualisation of mental illness led some to perceive of it as a distant category that could not be understood or even imagined without experience. In fact, 'real' mental illness was seen as something rare that happened to just 'the select few' (i.d. 7) and not themselves.

'Normal' and 'non-genuine' mental distress

All interviewees described an opposing category of non-illness. This category was 'normal distress' and was composed of what were regarded as common feelings and problems. They included within this all residual forms of mental disorder or distress that did not reach the severity they associated with 'real' mental illness. Most interviewees therefore described a continuum of normal distress from insignificant 'stress' and passing unhappiness to various severities of depression but this continuum did not extend into the category of 'real' mental illness. Instead, the two categories were polarised by an almost impenetrable threshold.

There's normal feelings of stress or depression or whatever that people just have at various points in their life and some people have more or worse or longer than others but that's not the same as illness – mental illness I mean – that's another category (LB: But aren't they just degrees of the same thing?) Um (2) I don't think they're the same at all. I mean like mental illness is like breakdown, something that takes control of the person's life and that's different to (4) feeling bad as part of life (23: female, 24yrs).

Also in the category of 'normal distress' was non-genuine distress perceived as a fad largely attributed to young adults and youth culture (see below).

The continuum of 'normal' distress

Interviewees described mental well-being as a state of happiness and a total absence of stress. However, this was seen as an unrealistic and generally unattainable ideal.

(LB: What about emotional health? Is that something different?) Yeah, I reckon. I suppose someone that's just happy all the time. I don't know, kind of a stress free life I suppose. But I don't think anybody has got a stress free life have they? Be a bit too much of a perfect person really so (22: female, 23yrs).

Some feelings of stress, distress and misery were therefore regarded as an expected, normal and universal part of life and human nature.

Its natural, its human nature, you've gotta go through bad patches, no one's life's perfect, no one goes through seventy years of their life loving every second of it, enjoying every bit, they've gotta go through bad and good (6: male, 17yrs).

This could even include more obvious symptoms such as paranoia:

(LB: what sorts of things would you include in psychological health?) Um, depression, schizophrenia, that sort of thing, paranoia. (LB: Do you see things like that as illness?) Um, no. I think everyone gets it to a certain extent, it's just certain people are more open about it... (LB: do you mean it's sort of normal to feel that way?) Yeah, it's a value inherent to being human that we should all feel that. (LB: but is it worse for some people, or just that some people talk about it and other's don't) um, yeah, I think it's worse for a select few but I mean pretty much every human has like paranoia and miserable times but they also have good times as well (9: male, 17years).

In fact, several interviewees had an expectation that everyone would experience a significant bout of depression at some stage in their life and that therefore this is 'normal' and one (*i.d.* 6) thought the same about feeling suicidal.

Most interviewees saw normal distress on a continuum of increasing severity. Across this continuum, distress was contrasted with real 'mental illness' reinforcing the separation of the two categories. Life events were seen to be the main cause of distress and sometimes as the distress itself and so were part of this continuum, with events of increasing severity coinciding with levels of distress. The continuum began with trivial and fleeting stress and unhappiness provoked by what were evaluated as minor and inconsequential problems with work and friends. This type of 'stress', sometimes called 'depression', was associated with a modern tendency to complain casually and unnecessarily - words such as stress and depression becoming common currency.

Its like at work, people go around bitching 'I'm so stressed. I've got this to do and I've got this to do', you know, I just feel like chucking the kleenex and saying 'alright, do you just want to shut up now?' you know, 'you've got your house and you've got your wages and you've got your job...people overuse the word (stressed) and the relevance of it, the meaning of it sort of dilutes (19: male, 23yrs).

After trivial matters were stressful life events such as exams, moving house and changes of employment. It was accepted that such events cause some level of distress but this was regarded as normal and commonplace. Further along the continuum were more serious events or an accumulation of events, which interviewees believed could lead to 'over stress' and feeling down.

At the far end of the continuum, interviewees included all episodes of distress and mental disturbance that did not fit the extreme criteria for mental illness. This meant that even 'abnormal' and severe episodes became included within the category of 'normal'

distress. It was here that the continuum ended and 'normal' and 'real' distress became polarised.

In my eyes you've got stress and then you can kind of go over the edge of stress and it's like mental problems... (LB: Right. So how do you know whether you're just stressed or whether you've got mental problems?) I would say stressed is when you literally can't cope with getting up in the morning, that's the kind of thing that I would say. You've got to that point then when you can't do anything, you don't want to go anywhere. (LB: So that's stress?) Yeah, to me, in my eyes. (LB: And how about mental problems? What would they be?) Oh um getting close to the edge and as it says down here (refers to GHQ) feeling like life isn't worth living and you know, contemplating taking your own life, I think that's, you know, but also you've got people who do go on to drugs or whatever and alcohol that kind of thing (17: female 23yrs).

While attitudes and responses to those in the category 'real' mental illness were stigmatising, responses to those in the category of 'normal' distress were dismissive including suggest that there is 'nothing wrong' with those suffering from distress and that they will simply get over these feelings. This applied to distress throughout the continuum of 'normal distress'.

My view is that everyone gets stressed or depressed its just part of living, its totally normal, even when its quite bad you know, I think that's normal, that's not being ill. People get over that in time. I think a lot of people feel quite sorry for themselves and end up in some self-imposed misery when really they'd be better off just getting a grip (laughs). I sound like one of those people who say pull yourself together and that but in a way I do agree with that because real mental illness or real depression is in a totally different league. There's just no comparison and most people just moan away when they really don't have a clue (23: female, 24yrs).

Non-genuine/'teenage' distress

Many interviewees – especially males - also described a non-genuine form of distress, which they associated with young people and placed within the category of 'normal' distress. This involved melodramatic displays of distress in response to trivial 'teenage' problems, casual over-usage of the terms 'stressed' and 'depressed', and 'manufactured'/fake distress. Manufactured distress was believed to be prevalent amongst young people and a part of youth culture. Several described it as a 'fashion' or 'fad' and it involved their peers supposedly falsely claiming or exaggerating distress to gain attention or appear 'cool':

There was a friend of mine who was, um, there was always something wrong with her. She did have a physical problem but she was an alcoholic and then she was a self-harmer and then she was abused by her father and every week it was something different and she went to go and see a counsellor and everyone just

took the piss out of her because they thought she was a nut. I still think she was an attention-seeker as well (15: female, 18yrs).

Kurt Cobain of Nivarna shot himself in the head, couldn't take the pain anymore, couldn't take being famous, heroin addict, you know, but revered by millions. I never bought into that, I never thought that was chic and I never thought that was cool but there's so many who think it is... they think its cool to have slightly greasy hair and go round all screwed up and pretend like 'argh the world's all against me' and all the rest of it and 'just bung me the "nine inch nails".... and they're all happy and that stuff but when they go out at night they make the big play because you know it's cool to be tormented in this day and age. Well it's not cool to be tormented, you know, we had a couple of people come to (psychiatric ward at local hospital). I mean that's what mental health is all about just people gibbering in their room on lithium and stuff...If you took all those people up there, all those indie rock posers and showed them that, then I think they'd get straight back into singing the 'backstreet boys' and you wouldn't hear anything else about it (19: male, 23 years).

Believing that 'fake' distress accounted for the most 'distress' in young people, interviewees tended to be critical and disbelieving of peers who presented themselves as distressed. This could present an obvious difficulty for those who wanted to confide in their peers.

My mate went there (GP)...and he goes 'I'm pretty miserable at the moment' and basically the bloke went 'yeah, you're depressed clinically, have some drugs', like that, gave him some pills and he just walked round the next week going 'oh yeah, I'm a manic depressive' (LB: So do you mean there's no point in giving a name to it?) Yeah. Just encourages it. (LB: How do you mean?) well, the thing is you don't really think about it before and the doctor went 'yeah you're manically depressed' and he just went 'yeah actually I am'. It just put an idea in his head and then like grew on that idea. (LB: So it was turning it into a problem it wasn't do you think?) Yeah, it went away like any fashion does. (LB: Do you think depression's a bit of a fashion then?) Yeah it is. It's like 'oh I'm really depressed, listen to the Smiths and kill ourselves'. Teenage culture. (LB: Oh right). You can't have a functioning teenager you know. Just think of the mockery. (LB: But is it always a part of this fashion?) yeah, yeah, it is (LB: what? Always part of the fashion?) The majority....(LB: so not even your friend) No. He wasn't depressed in the first place (LB: right but his dad thought he was?) Yeah I think yeah something like that. I think they just suggested to him that he did it (went to GP) and he went in and went 'yeah, yeah I'm miserable' and I mean it sort of had a big effect, he came back the next day and like told everyone and was like yeah yeah (.) I'm depressed (LB: do you think he was glad to be able to say that?) Yeah he was. (LB: in what way?) He was (.) and he goes yeah I'm depressed, now they've got me on these drugs, taking drugs 'cos I'm depressed. (LB: you mean he thought it sounded cool saying that?) Yeah he did. (LB: right and what did you all [friends] think of that then?) Some people bought it, the more naive of us did, some people didn't and thought he was a complete knob (7: male, 17 years).

Distinguishing 'real' and 'normal' distress

Interviewees were asked how 'real' and 'normal' distress could be distinguished. The distinction hinged round various markers of severity surrounding the nature of symptoms and the causes of distress. To qualify as 'real' rather than 'normal', episodes had to be sufficiently severe and long lasting, if not of indefinite duration, and to be accompanied by visible, constant, disabling and pervasive symptoms, including a complete inability to rise from bed and an inability 'to cope'.

Constant, it would have to be constant really or you know going through quite a long period, a long phase of your life like that (depressed) (8: male, 17yrs).

I think proper depressed would be a complete lack of interest in anything, not being able to talk to anyone and not being able to find enjoyment in anything and sort of a very bleak outlook on things (1: male, 20yrs).

'Real' depression was those episodes accompanied by suicidal feelings and/or insanity.

I think it (depression) is serious because it can make you do lots of things a sane person wouldn't do really. (LB: Right. What sorts of things?) Well people with depression probably feel, major depression, suicidal, um, if they had children, probably neglect the children and the family and not be able to cope (18: female 18yrs).

(LB: you were saying it's kind of normal to feel depressed from time to time but at the other extreme you can get chronic depression. How do you know where you are on that scale?) I think if you can cope with it, if you're not so depressed that you're thinking I really can't be bothered with life anymore, then that's when I think you need to, I don't know, talk about it (12: female, 18yrs).

In keeping with physical definitions of illness, many interviewees conceived of 'real' distress/ mental illness as only those mental disturbances they saw as genetic or the result of biological dysfunction.

I think it's too hard to understand what proper mental illness is. I think mental illness is like schizophrenia and things like that. I suppose that I could call an illness 'cos a genetic (.) If I thought it was actually to do with the brain, it's something physical, I would call it an illness but as far as things with feelings, emotions and things like that go, I don't think I would call anything like that an illness (1: male, 20yrs).

Interviewees also described a hierarchy of life events or 'reasons' for distress ordered according to seriousness and used this to decide whether or not distress could be 'real':

You can tell usually if they're (people claiming to be depressed) genuinely depressed like, you can tell by what's happened in their life and stuff (7: male, 17 years).

There was a strong sense that only certain events could provoke ‘real’ distress. These had to be extreme, unusually severe, irreversible and long-lasting, and were often traumatic events occurring during childhood.

(LB: What sorts of things could be wrong (in cases of mental illness)?)...I personally believe a lot of things will stem from childhood, if you’ve for example been beaten as a child, I don’t know, raped as a child, that kind of thing, had a really bad family life (13: female, 20yrs).

Outside of these extremes, as noted above, a continuum of other life events, including any problem that could be resolved over time, or rationalised was associated with ‘normal’ (non-illness) depression.

Obviously something that’s going to go on for months, years, whatever, then obviously you can get depressed but not something that can get sorted out (LB: So it depends on the cause?) Yeah, it depends on what the cause is (17: female, 23yrs).

These criteria were used to judge the significance of actual episodes of distress experienced by themselves and peers, usually meaning that even severe distress was considered unproblematic (below).

An example: depression

Depression was discussed by all interviewees and in most depth. Interviewees clearly polarised this into the ‘real’ and ‘normal’ as evidenced by the variety of ‘types’ of depression that they identified and the terminology used to describe this (Table 6.4).

Table 6.4: ‘Types’ of depression described by interviewees

Non-illness/ ‘Normal’	Illness/ ‘Real’
Everyday/ casual ‘depression’ A ‘phase’ ‘feeling down’ (Personal) problems fashionable ‘depression’	Real, actual, proper, true Manic/ chronic Clinical/ Psychiatric Major/ complete ‘Depression depression’

All interviewees identified a ‘real’ form of depression that was distinguished by its severity and permanence. ‘Manic’ or ‘chronic’ depression were terms commonly used to denote this and to describe an extreme form of symptoms rather than a clinical diagnosis. Most ‘depression’ however, was thought to belong to the category ‘normal’/ non-illness.

I think everybody can get depressed from time to time so I don't really consider it illness because unless they've got chronic depression where they're depressed all the time I just see it as a part of everyday life really (12: female, 18yrs).

As with the general category of 'real mental distress', 'real' depression was stigmatised and associated with drug treatments.

If you're manically depressed and start taking Prozac to get rid of it then you can become dependent on Prozac 'cos I mean I used to work with someone who was and I used to stay away from him in case they said 'no Prozac' and withdrawal started to have effects or whatever (10: male, 16yrs).

For most interviewees, concepts of 'real' and 'normal' depression mapped directly onto the framework of 'normal' and 'real' mental distress. Most believed there were exceptional forms of depression that could be regarded as illness:

I think it can get to be an illness...it can be a really horrible or severe thing, where it gets to the point that you don't even want to get out of bed, where you just want to lock yourself indoors for weeks on end just not see anybody um so yeah I think in its worse form it's definitely an illness not something that you spread quite obviously but just something that really affects your life in such a big way in its major form (13: female, 20yrs).

(LB: Do you think that depression is an illness) Well it can be, like manic depression (16: male, 19yrs).

However, other interviewees were unsure about whether or not even extreme depression could be regarded as illness because it did not fit criteria attributed to 'real' distress such as permanence:

(LB: What is depression though? I mean is it an illness or is it something else?) um, I wouldn't class it as an illness. I don't know what I'd class it as (5) just a stage you go through in life. I mean in some ways it would be an illness because yeah you get prescribed medication for it, so therefore it is classed as an illness, but um you can overcome things and it's hard to say, um, I really don't know (11: female 21yrs).

Five interviewees did not perceive 'real' depression as illness at all, despite the severity they attributed to it, and in one case even calling it 'clinical' (i.d. 1) on the grounds that 'feelings' do not have an underlying physical basis. Such interviewees required an external justification such as the results of a blood test before they would accept depression as illness.

(LB: Do you think depression is an illness?) I don't know if I could call it an illness. I did a play about mental health a couple of years ago and we did a lot of work on the characters and things like that and we were told that it was an illness and we did a lot of research into it being an illness but I think I still came out with the feeling that it wasn't an illness as something you can catch.

It's something I think some individuals are more prone to develop than others. I wouldn't actually call it an illness. (LB: So if it's not an illness, what is it?) I don't think I could actually come up with a name for what it is. It's a thing that comes and that you hope eventually goes... (LB: Do you think even the extreme of depression you described isn't an illness then?) No I still don't think I'd describe it as what I would term as an illness (1, male 20yrs).

I always think of illness as like ill in bed, like cancer is an illness, leukaemia is an illness, depression is something that happens... I mean like if someone could show me medically, 'here we go, this is someone who's got depression, this is someone who hasn't, look at like, I don't know, blood, whatever, you know there's the results', I'd be like 'oh, okay, so it's an illness' (3, female 20yrs).

In such instances, even severe depression was described as 'a phase' and did not cross the threshold into 'real' mental illness but was added to the volume of distress normalised in the category of the 'everyday'. Similarly, some interviewees placed 'real' depression after stress and 'normal feeling down' on the continuum of normal distress so that it occupied a place near but not over the threshold between normal distress and mental illness, and some of these interviewees considered that depression could progress to 'cause' illness.

(LB: We spoke about depression and I was just wondering where you see that as fitting in with stress and mental problems?) I would say that's in the middle. That would be 'cos you know you can get stressed about something and then it would be sorted out in the next couple of weeks but I think depression you know you can slip into depression which obviously can go deeper and deeper and then bring on the mental health side of it (17: female 23yrs).

Susceptibility to 'real' mental distress

Interviewees held beliefs about who might experience 'real' distress or depression (Table 6.5) and these were used to judge whether episodes of distress, for instance in peers, were likely to be 'real'. It was commonly believed that some individuals are more prone to mental disorder than others due to particular personality characteristics and that 'real' distress is explained by a lack of strength or willpower, which some linked to upbringing. Some interviewees suggested those who cross the threshold between 'normal' and 'real' distress are people who 'wallow' and do not act to change their situation and therefore implied it was the fault of the individual. Most interviewees located real distress with older people, or had done so prior to their own experiences, believing that to be depressed in the context of young adulthood did not make sense. They saw young people's problems as low in the hierarchy of life events and not 'bad enough' to cause 'real' distress. In contrast, a smaller group thought depression could

occur as much or more in young people due to the transitions of ‘growing up’. A small number referred to the occurrence of suicide in young people as an example of this. This may also be attributable to their personal experience since these were interviewees with experience of diagnosed depression.

Table 6.5: Common beliefs about susceptibility to ‘real’ mental distress/ depression

Personality/ pre-disposition <ul style="list-style-type: none"> - Introverted, shy, withdrawn - Sensitive - ‘Deep thinker’ - ‘Worrier’/ ‘stressy’ person 	<p><i>I think quite shy withdrawn people are probably more likely to be like me [have distress] whereas outgoing and outspoken people will probably never suffer mental things (18: female, 18yrs)</i></p>
Lack of strength or willpower <ul style="list-style-type: none"> - Inability to cope - Inability to handle pressure - Lack of determination - Weakness - Those who mope or wallow - Those who ‘give in’ 	<p><i>Some people are strong and can cope with almost anything life throws at them whereas some people are weak and can't and people who can't are more susceptible to becoming depressed (10: male, 16yrs)</i></p> <p><i>There are some people out there who don't have the confidence and willpower to sort their life out, get a job, enjoy themselves rather than ‘nothing's going right for me I'll just kill myself, there's no point’ (6: male, 17yrs)</i></p>
Age <ul style="list-style-type: none"> - After 30 - ‘Middle age’ - ‘Mid-life crisis’ - ‘Adults’ problems 	<p><i>I think at our age you're still immature so I don't think they (young adults) really do go through serious depression. Once you're an actual adult then you've got much more of a wider experience of life and stuff so I think if something serious happens then you know then that can get an adult down...(LB: right. When you say ‘adult’ what sort of age are you thinking of?) er (1) I'd say over thirty really (8: male, 17years)</i></p> <p><i>I reckon serious depression is a bigger problem for um middle-aged, mid-life crisis people. I think its quite um (2) where ever you find the young depressed person its only just a small part of their life and they've still got their whole life ahead of them and to be depressed at that point I reckon would just again be part of some sort of fashion. I've never really met any depressed young people before (7: male, 17yrs)</i></p>

Three interviewees also attributed the occurrence of ‘real’ distress to bad luck and two (both male) discussed a possible relationship with gender, with both believing that women are more susceptible to distress. The remainder thought there was no particular gender relationship but gender differences were thought to exist in relation to help-seeking and coping (below).

Beliefs about help and help-seekers

The point at which interviewees considered help to be ‘needed’ reflected their polarising of mental distress into the ‘normal’ / ‘non-illness’ and ‘real’, ‘illness’ categories. ‘Need’

was located with extreme mental illness but not with 'normal' distress or depression that had not passed this threshold. 'Normal' distress and problems such as exams and relationship difficulties were seen as temporary and so not requiring 'help'. Informal lay support, pressure-relieving strategies, or coping alone were the recommended methods of dealing with this.

(LB: Do you think people don't associate the doctor with psychological things) I think they do but only if its really bad like you wouldn't go to see your doctor about feeling depressed just like that. It'd had to be that you were really depressed you know. (LB: Why is that?) I dunno, it just doesn't seem like something you'd treat and call illness that easily because I mean we all get it at times don't we, so its got to be pretty abnormal in intensity or effects or however you'd measure it before you could say it was pathological (23: female, 24yrs).

Help was therefore thought to be needed in 'extreme circumstances', at 'crisis point', when suicidal, and when 'real' depression is 'very bad', or when the person can no longer 'cope', ie. rarely.

(LB: When do you think someone needs to get help for something like depression?) (3) um dunno it's a hard one to answer. I suppose when you're in quite a bad state, when they're thinking of taking their life or something (LB: So its got to get quite bad first?) I wouldn't say it has to get quite bad I just (.) well no in the stages of manic depression I'd say you should get help (16: male, 19yrs).

That is when I see the time to go and get help is, when you see it as being too late and you've tried absolutely everything there's nothing else you can do and you get trying to sort of take your own life sort of thing (LB: right so you would go for help before you got to that stage?) I think I'd consider it around that point (Male: 20yrs)

'Real' distress and the 'need' for help were circular definitions. Some recognised distress as 'real' when it was treated by professionals and with medication. This meant 'help' also had a role in separating 'real' from 'normal' episodes.

You do need to see professionals if you are going through [real] depression so if it calls for that sort of action then I do see it as an illness (8: male, 17yrs).

There was a common belief that many people 'bottle up' distress rather than seeking help or informal support and many interviewees depicted help-seeking as a matter of personal preference rather than necessity.

(LB: What could people do to stop it [depression] or to feel better?) I don't know, I think it's different for individuals in what they feel would be best for them to overcome it. I mean some people might want to talk to other people and explain how they feel and talk through it that way, other people might want to keep it to themselves and change other things in their lives until they don't feel

depressed...(LB: Do you think people with depression ever need outside help?)
 Yeah, I think some people (1) I think again it depends on the individual. Some people may seek and want that outside help and other people may prefer to deal with it personally (4: male, 21yrs).

Several interviewees discussed ideas about which types of people seek help (Table 6.6).

Table 6.6: Beliefs about the typical characteristics of help-seekers

Personality	I wouldn't talk to any of my friends about my problems...It's just me. Personally I don't really talk about myself a lot. Ever really... you know, people deal with different things in different ways. I have friends that feel they can talk to me, and I'm quite happy to sit there for hours whilst they cry or do whatever, but me personally I don't like to do that (22: female, 23yrs)
Upbringing and family	I think it's a family thing too, I mean we're not really like that, we don't talk about problems or show emotion like to cry in front of someone. Its like we'd be stronger than that. (23: female, 24yrs)
Lack of strength/ willpower	Some people can be less confident and weaker than me, can't handle it on their own, they need their family or their friends, or maybe even a counsellor to help them get through bad patches in their life. (LB: so do you think it's a sign of weakness to have to go and get help?) Yeah, not physically weakness but weak in the mind not strong enough to handle situations (6: male, 16yrs)
Age - Young people are stronger so have 'less need' - Young people don't seek help	Young people are mentally strong and they hopefully can overcome it on their own without the help of someone specialist (6: male, 17yrs). I can't imagine anyone in my age group going to get help. I don't know why I consider it as an older person's thing but I do and when the girl from our course started getting help I thought it had become a very serious problem because she was so young. I think the only reason she went to the counsellor anyway was through the [tutors]. I don't think left on her own that she would have done and I don't think that any of her peers would have suggested it (1: male, 20yrs)
Gender - Males are stronger so have 'less need' - Less socially acceptable for males to seek help	If a girl told me that she's seeing a counsellor I'd think that was bad and she must have some sort of problem. If a man went I think I would see it as being not worse but I'd imagine him to have almost a worse problem because I think a girl would be more likely to seek help and if a man went I'd be surprised that he did. I'd have thought that he'd of kept it to himself or perhaps discussed it elsewhere (1: male, 20yrs)

Paralleling ideas about susceptibility, the tendency to seek help was again related to personality, lack of personal strength (particularly amongst male interviewees), and age. Many interviewees also related help-seeking to gender and upbringing. Interestingly, no interviewees considered themselves to possess the help-seeking trait (see, for example i.d. 22 - Table 6.6).

Summary

Interviewees polarised distress into two distinct categories – the normal (non-illness) and the real (illness). ‘Real’ distress was stigmatised. Only rare or extreme forms of distress were seen to belong to the category of ‘real’ distress meaning that significant episodes could be encompassed and dismissed within the scope of ‘normal’ (non-illness) passing experience. Many interviewees believed that young people rarely if ever suffer ‘real’ distress. The need for help was perceived as only necessary in the presence of ‘real’ (stigmatised) distress, while normal distress was associated with ‘coping’. The chapter will now describe how interviewees made sense of their own episodes of distress in relation to this framework and how the beliefs surrounding it influenced their illness behaviour.

Illness behaviour

A key theme in all interviewees’ narratives of experiencing and responding to their own distress was the struggle to recognise and evaluate the significance of their own mental symptoms. They became engaged in a process of trying to define whether their distress was serious and represented ‘real’ distress. This process was problematic for all interviewees, yet how it was resolved – typically a process of avoiding resolution – was central to subsequent help-seeking behaviour, since definitions and assessments of distress were closely and at times inextricably linked with perceptions of need for help. The difficulties of recognising and evaluating symptoms, the outcomes of this struggle, and the issues influencing this – the social meanings of help and ‘real’ distress – were discussed in the reflective retrospective accounts of past cases and those with long trajectories of mental distress and were also evident as an ongoing dilemma in the narratives of current and some chronic cases.

Recognising and evaluating mental distress

Several interviewees described an initial difficulty in recognising their feelings as symptoms of potential mental distress. They drew many contrasts between the nature of mental and physical illness, attributing their difficulties to the specific nature of mental distress. Interviewees were particularly unfamiliar with the notion of non-physical illness and this hindered their recognition of mental distress. While recognising and

responding to physical symptoms was obvious to interviewees, this was not true of symptoms of mental distress. Holding primarily physical conceptions of health and illness (above), some had ruled out the possibility that they could be ill or in need of treatment:

I thought to myself oh this can't be right but at the same time I didn't think because I didn't think that I had like a leg hanging off or anything like that I should go to the doctor's so that's why I didn't bother (3: female, 20yrs).

Others had misinterpreted their distress as physical in origin and three had presented to their GP with complaints such as nausea and muscular aches:

I took a lot of Nurofen and I just thought, I mean they did help but not as much you know and it just you know I took loads of those tablets and they just made me go a bit weird in the head taking loads of them like that (LB: Why did you take them? Because you were feeling upset?) Yeah. Upset and I just wanted to take the pain away, it's like I get it now still if I don't take my tablets [anti-depressants], I get pain all the way through and it's like there [in chest] and all over and it's like hard to handle. (LB: But you didn't have any idea that it was=) No I just thought it'd be something physical you know (21: male, 18yrs).

Two interviewees attributed their lack of familiarity with mental distress to their young age and a corresponding lack of experience of mental health issues.

I think this is especially with young people, you're not so aware of mental illnesses as you are brought up with the idea of physical, so perhaps if you knew something was wrong with you you'd probably claim it as physical anyway and use that to identify what it is and not associate it with a non-physical thing...when I was really ill I went to a doctor and described physical illnesses to them...because I didn't know what it was, what was happening. I just guessed at it (2: female, 19yrs).

Aspects of the particular nature of mental distress and symptoms presented problems for recognition. A small number discussed how distress had a gradual and less obvious onset than many physical complaints and how, during this time, they had increasingly accommodated their symptoms. They then required an external source, dramatic event or major interference with their life to draw attention to the situation.

If you got a letter in the post tomorrow, and it said right you're going to be really stressed and you're going to try and kill yourself, you're going to think well I'm going to go to the doctor then. Cheers. Or you know if maybe you have trouble, I don't know, going to the toilet or you start throwing up then you might say right I'll go to the doctor but when it just creeps up on you over that period of time. You know and it was a period of time...just looking back now I'm like well its kind of obvious now but at the time. (LB: At the time you didn't realise what was going on?) Yeah. But because it sort of takes so long to build up...with mental health you don't know what's happening until it's too late because it does just sneak up on you (19: male, 23yrs).

The subjective, 'non-visible' nature of mental symptoms also made these more difficult to detect than physical symptoms.

Physical health you can see what's wrong I think. You can feel it. You know, if I can't move my arm or it hurts when I move my arm, then I've got to think there's something wrong with my arm. If I'm not keeping my food down then I've got a stomach bug or something...they are things that people can see, you know, 'good god man, his skin's turned yellow, right you've got jaundice, we're going to do something about that...whereas with mental health people don't, do they? (19: male, 23yrs).

Symptoms could also cause cognitive disturbances in perception and become internalised as negative aspects of the self rather than signs of distress or disorders. This was particularly true of those that undermined interviewees' self-esteem.

I don't think I really realised it was depression at the time. You do feel very low in yourself, you don't really wanna do anything that sort of tests your ability as such....you don't actually know but you do have the symptoms yes, great lack of confidence, low self-esteem, you don't really wanna do anything, you just wanna stay in bed. (LB: So what did you think was going on with you?) I think that towards, you know, perhaps the last month before I finally was not well enough [to go to college] I think I finally realised I might be depressed....you just think that you can't do anything and that you really probably couldn't do anything in the first place. (LB: So you start to think it's something wrong with you personally rather than that you're ill?) Yes, that was definitely how it affected me...I suppose I didn't truly realise I was depressed until the doctor (1) it's very hard to understand depression (14: male, 18yrs).

When interviewees did identify their feelings as those of mental distress, they struggled to decide how important these were and whether or not they constituted an actual 'problem'. In turn, this impeded their assessment of whether they 'needed' help. Some acknowledged that they lacked clear understanding of mental distress and that this made it difficult for them to define their own experiences:

I think I'm quite down all the time. Like even though I seem happy all the time I'm actually not very happy at all...(LB: Do you think that's normal to feel down all the time?) No, I don't think so. No. (LB: So what do you think that could be?) I honestly, I don't actually know, I don't know...but I don't really know the cause of why I'm down all the time. But I've just found it harder to deal with lately really. (LB: Is that because it has got worse?) I think so yeah, yeah. (LB: So how's that different to what you were describing as depression? You were saying that was being down all the time?) I kind of, I don't know, like I suppose sometimes, I don't really know what depressed is I don't think. So I wouldn't say that I was depressed. (LB: You wouldn't say you were because you don't know what it is?) Yeah [laugh]. So I might be depressed I don't know [laugh] (22: female, 23yrs)

Mainly, interviewees explained their difficulties again in relation to differences between the nature of physical and mental illness. While they saw physical illness as categorical,

visible and objectively defined, they considered the opposite to be true of mental distress and that they lacked a comparative measure or benchmark to rate the significance of where along a continuum of distress their experience fell.

I think if you need to see the doctor you pretty much know [if you have a physical complaint] but if you need psychological help you don't know, so I think that's the difference there (LB: why don't you know with the psychological?) Because you can't see it. You can go like 'oh look at that cut and think the muscles cut but you can't compare minds of people when you don't know how anyone else's works...I mean I could be the happiest in the world and I could be the most depressed person in the world - I wouldn't really know (7: male, 17yrs)

In the absence of such clarity, interviewees reverted to the polarisation of 'normal' and 'real' distress (above) as the framework for evaluating their experience and the process of evaluating the significance of distress became one of trying to deciding whether their distress was either 'normal' / 'everyday', or 'real'. This was also a means of deciding whether their distress was 'bad enough' to require help, help being associated with 'real' but not 'normal' distress. However, the limitations of this binary framework and difficulties interviewees experienced in making the distinction were striking. In practice, they struggled to identify where 'real' distress began and how 'bad' this should feel:

(LB: so there are different types of depression?) Yeah, there's feeling unhappy and there's being ill. (LB: So how do you distinguish the two?) By how long it lasts, by how intense it is, what effects it has, whether it's temporary or inescapable. If you can say oh I'm depressed about something and then just carry on as normal that's different to having to live and breathe depression all day. I mean proper depression is much more than just a feeling about something, it's a state, a really overwhelming and oppressive state. (LB: So the two types aren't hard to tell apart then?) hhh (3) um no they are or they can be. I'm not sure because there have been times when I was depressed and I wondered whether I was or not. I mean I knew I was but I didn't know whether it was anything out of the ordinary or not - like proper depression if you see what I mean. (LB: So when does normal depression become something out of the ordinary?) Well that's the problem 'cos you can't exactly measure it. It's not an either or type thing that you either see or you don't like spots. I still find it [depression] hard to grasp just 'cos there are no definite boundaries for it or ways of recognising it or not so much recognising it as knowing when it's real (23: female, 24yrs).

Interviewees' accounts were characterised by two further themes revealing that the process of evaluating distress was complicated by a reluctance to place themselves in the category of 'real' distress. This was most evident where symptoms could not easily be perceived as casual and everyday, for instance, amongst those interviewees with clinically significant CIS-R scores (eg. *i.d.* 7, 9, 10, 15, 23). These and several other respondents (eg. *i.d.* 1, 4, 11, 13, 17) instead sought (or had sought) an intermediary

position, near but not crossing the threshold into 'real' disorder. The first theme was a tension between classifying distress as 'real' and avoiding the possibility of being, or being seen by others as, a hypochondriac.

(LB: You seem to be calling it [her distress] depression. Do you think that's what you're going through?) I don't know what it is. I wouldn't say I'm depressed, I would just say that I am really overstressed. But I suppose you could call it depression because the thoughts [of suicide] I get sometimes with it...I don't know because it is quite hard to decipher each one. I mean when do you say that stress is depression or depression is manic depression? ...if you've got a pain in your leg it's either a dull pain or an ache but it's got a certain rating and then you can say this is what's wrong with you but with psychological health it's all to do with the person, only they know how they feel and how do you say when somebody's upset or somebody's seriously depressed? (LB: Does that make it harder to cope with?) Yeah because in a way everybody says they're stressed so you kind of feel like you're being a bit like a hypochondriac (15: female, 18yrs).

The second theme was a desire to disassociate themselves from the extreme characteristics attributed to 'real' distress – in particular, to avoid the stigma:

I have thought a couple of times life isn't worth living but I don't know that I've got the balls to go jump off the bridge or anything. It is quite worrying sometimes when I just sit and think, 'oh I wish I had a gun right now' and I just think 'no, I don't want to think that', and I just worry that I've got two brains...I'm not quite screwy but I'm not quite sane either, I don't think. I'm leaning towards the sane I hope (10: male, 16yrs).

I couldn't say if I've actually had a mental illness or anything like that. Its when you say it like that it sounds like a very very big thing. Then it sounds like this huge (.) its got this stigma attached to it, whereas if you talk about feeling down I wouldn't call that an illness if you know what I mean (1: male, 20yrs).

Normalising distress

Interviewees tried to resolve the difficulties and uncertainties surrounding the recognition and evaluation of their distress throughout the illness trajectory. Their friends, family, peers and other lay members also became involved in this process. Mainly, these attempts resulted in normalising their experiences – that is, locating these within the category of 'everyday', largely insignificant non-illness distress that did not require help. Only rarely did they associate themselves with having 'real' distress requiring help. This also allowed them to fulfil their desire to disassociate themselves from the stigmatised category of 'real' distress. Mental distress was particularly amenable to normalisation because of its gradual onset, which allowed symptoms to be

accommodated, the non-visible and non-categorical nature of symptoms, and the casual usage of 'stress' and 'depression' in everyday life.

Rationalising distress

Rationalising distress was one means of normalising. Interviewees derived alternative explanations for their symptoms, which defined them as non-illness and something other than 'distress', and which typically downplayed their significance. This included explaining distress as simply a personality trait thus discounting symptoms by describing oneself as a 'stressy', 'unhappy', 'moody', 'melancholy', 'deep thinking' or a 'worrier'.

(LB: What did you put that [symptoms of depression] down to?) Just my personality. Because I'm quite introverted anyway and I've always been like that, I've never been hyper or anything, I've always been a bit melancholy (16: male, 19yrs).

In other cases, symptoms such as lethargy and lack of concentration were interpreted as 'bad' behaviour or negative traits such as being 'dumb' or 'lazy', reinforcing their low self-esteem:

I could not sit down and concentrate doing my [school] work and I blamed it on I was dumb. I just thought I was dumb, I can't do the work (21: male, 18yrs).

Distress was often seen as inseparable from a current life event or problem, for instance with work, studies or relationships, and this was used to rationalise and dismiss symptoms as a normal feature of life.

(LB: Did you think you were suffering from that?) Not originally, no. I was stressed out over my A levels, I just thought A levels you know, c'est la vie (19: male, 23yrs).

Similarly, distress could be accounted for by other external factors such as a problem with 'life' itself or society, rather than being defined as a problem of the individual.

Sometimes you don't think "its depression" and "oh that's an illness so I must go and see someone and get cured", you just think "everything is crap, life is so bleak and awful and I just want out" (23: female, 24yrs).

Alternative explanations for distress in young adults

Young adults' distress was also easily normalised by the number of readily available explanations discounting symptoms as expected teenage 'angst', 'problems' or

'hormones'. These derived from the belief that young people do not suffer 'real' distress or encounter the types of problems that can cause this (above) and were adopted by interviewees as a means of accounting for their experiences:

Lack of sleep [interviewee's insomnia] I just thought was being a teenager really (LB: Being a teenager?) Yeah I just thought it was just being a teenager....I guess I only realised I was depressed was when I OD'd so... I mean like if you asked me six months back, I'd say fine, its just my age I don't care, I don't give a shit (16: male, 19yrs).

I didn't actually know what it was I just thought oh well I don't like going out, I don't want to see anyone, I don't want to do anything, I thought maybe that's just teenage years (3: female, 20yrs).

Friends and family also normalised interviewees' distress with reference to these explanations, particularly when the interviewee attempted to seek their help or advice about symptoms.

(LB: Did you talk to anyone about how you were feeling at all?) Um my mum but she was like 'oh well you can't be depressed you're too young, you only get depressed when' (.) she goes 'you've got no problems', she says 'you're not (.) you only get depressed when you get about above thirty', she put like an age on it...(LB: How did you feel when she said that?) I thought oh my gosh, I thought I must be imagining the whole thing so I thought oh maybe I am you know, so I tried to get on with it and I thought try to ignore it but it got really bad, I just wouldn't go out of the house and I took days off school and it was quite bad (LB: What did your mum do then while you were taking days off school and=) =She just thought that I'd get over it, it was just a phase I was going through (3: female, 20yrs).

Emphasising and extending the extreme criteria for 'real' distress

Normalising was also accomplished by emphasising the extreme character of 'real' distress and the criteria for this. Interviewees treated 'real' distress and the 'need' for help as relative concepts, which allowed them to negotiate their position within the polarised extremes of 'normal' and 'real' distress by repeatedly shifting and re-considering the boundaries between the two. Interviewees did this in relation to their symptoms and perceived ability to cope, what they considered to be the 'reasons' for their distress, and the images they had of 'help' because definitions of 'need' for help and 'real' distress were inextricably linked and circular definitions.

Evaluating symptoms and ability to cope

The 'everyday' nature of some mental symptoms and usage of words such as depression and stress meant that distress defined as depression could still easily be viewed as

normal and disregarded by interviewees and those around them as 'a passing phase', 'just stress', 'pressure' or 'normal depression'.

I didn't believe there was anything wrong. (LB: what did you think was happening then?) Just that everything was normal and just thought I was a bit depressed I suppose (16: male, 19yrs).

Interviewees attempted to evaluate their distress on the basis of severity using their polarised framework for classifying distress as a means of doing so. However, this led them to normalise their own experiences because it meant that they evaluated the significance or 'realness' of their own distress in relation to their extreme images of 'real' distress – this becoming the benchmark for categorising distress. Almost all episodes were disregarded as normal unless they could reach this extreme:

Extreme depression would be like depressed, I suppose from what I've heard, is just depressed all the time but I don't feel depressed all the time so I'm pretty sure I can't be [have 'real' depression] but that's only what I've seen and heard like through the media and stuff and books (7: male, 17yrs, CIS-R=15).

If you actually think about what depression really is then you don't come close sort of thing...there's the sort of depression where you can't get out of bed and you've just had enough generally and I don't think I've ever really had that so I wouldn't say I'm depressed, I'd say I've had a bad time of things for say longer than a couple of weeks or a month or (2) and (1) or its been a bad couple of months but I wouldn't say actually depressed...I think I hit the middle of the scale I don't think I was anyway near proper depressed...I don't think I ever had a day where I couldn't get out of bed. I had days where I didn't want to and it was most days I woke up and just didn't look forward to the day and I didn't want to get out of bed because I just thought it was a pointless exercise (1: male, 20yrs).

What was considered severe enough to indicate 'real' distress was relative. However distressed they became, nearly all interviewees were able to conceive of a more distressed or 'needy' state beyond their experience which then became the benchmark for 'real'. This allowed them to normalise their own distress by comparison and therefore to separate themselves from the extreme category of 'real' distress/illness and the need for help. This was a reason for not seeking help because help-seeking for their now normalised distress became non-legitimate in comparison.

I didn't ever see myself as being as severe as it could have been or as somebody else is. I suppose its how you rate your own situation, I didn't rate it as high enough to go talk to anybody about it um but I don't know I suppose yeah I was quite depressed (13: female, 20yrs).

I had lost basically two and a half stone in six weeks...I kind of realised 'what are you doing to yourself' [referring to eating disorder] you know 'cos

obviously I'd seen it on the telly and in the paper, you know, they're three and a half stone and they're dying and I thought 'I've got to sort myself out'...(LB: Didn't you think about getting any help?) I didn't think I was that bad. I didn't think that it warranted wasting their [doctors] time...you know, I'm not three and a half stone and my hair's falling out (17: female, 23yrs).

Interviewees also regarded 'not coping' as a sign of 'real' distress and need for help. As long as they believed they could manage their distress without seeking help, they could disassociate themselves from those with 'real' distress. This sometimes involved adjusting their personal concepts of normality to encompass and accommodate significant symptoms they acknowledged others might not experience.

I still managed to pay my bills, keep my mortgage going, work you know, bring up a little girl and when you think of it, well you know, I couldn't have been that depressed if I could do all that...the doctor said I was and I was going along talking to someone but I look back and think well was I really? You know, do I really suffer from that? (9: female, 23 years).

I often don't think its normal because it does stop me doing things or may be not so much stops as slows me down and it's not something that I see in other people. I don't see them affected that way, though maybe they are, I don't know, they could be, they don't really know I am. But yeah, at the same time I'm still going about life you know. It's just what's normal for me I guess. Most of the time I'm okayish and then I'll have a bout of feeling bad but I always come out of it and carry on (23: female, 24yrs).

I generally just stick on a good song and try and forget...(LB: Isn't it worth getting help to alleviate it [mental distress]?) It is yeah but I'd much rather kind of myself..whereas somebody with manic depression I'm sure they would much rather take prozac than feel the way they are feeling (LB: So you don't think a doctor could really help you at the moment?) No they couldn't I don't think..I can cope with things (10: male, 16yrs, CIS-R: 17).

Severity, the ability to cope, and other such criteria used by interviewees to identify when distress was 'real' as opposed to 'normal' were open to interpretation and negotiation and only determined in retrospect. Interviewees 'waited to see' what happened before defining their distress, and in the meantime, normalised their symptoms. For instance, the belief that 'real' depression is long lasting or permanent allowed interviewees to avoid defining their distress as 'real' almost indefinitely while they waited to see if feelings endured or 'got better' (*i.d.* 1, 2, 7, 9, 10, 11, 15, 17, 19, 21). Similarly, before deciding that distress was severe, and therefore accepting this as 'real', interviewees waited to see whether it could 'get worse' (*i.d.* 7, 9, 15, 20, 22, 23), and to reach the point at which they could no longer cope meant waiting until this point had passed (*i.d.* 5, 9, 15, 19, 22, 23) but the point rarely seemed to be reached.

(LB: Did it cross your mind at all to get any help?) No I didn't see it as that serious to be honest. (LB: what would make it more serious?) (12) um (4) I don't know it'd just be it'd be more (1) like being more depressed or something (1) 'cos it isn't just like the length of how long you're depressed, its like how depressed you get (LB: is that why you were saying earlier its hard to know if its normal or not?) Yeah its kind of like you don't know how far depressed you can get until you are that far in depressed...(LB: So you don't think it was real depression?) I think it was depression yeah, I don't know how bad real manic depression is so could have been, could not (7: male, 17 yrs).

(LB: How can you tell when you're not coping anymore?) When you're rocking in a chair (22: female, 23yrs).

These waiting strategies allowed interviewees to maintain the possibility that their distress was 'normal' and would 'go', despite experiencing significant morbidity and levels of suffering.

I think of depression as more of a long term thing, I would say years – months to years - whereas I am hoping that this is just overstress and that I am going to be able to de-stress soon and that I'm not going to feel like this anymore...I think only time will tell at the moment. If I get lower and lower and lower then it's gonna get to a point where I'm going to have to go and get help from somewhere, don't know where, but I might wake up tomorrow and feel on top of the world... (15: female, 18yrs, CIS-R=38 with suicidal ideation).

You take it day by day and you think oh perhaps the next day'll be alright or something like that, you know, I'll change (2: female, 19yrs, past case).

Some interviewees also normalised their distress with a belief that they had a personal ability to cope with distress and were immune to distress of a severity that could require help-seeking.

I don't think personally I'll become manically depressed or anything because I'm a quite strong person, I'd be able to cope with it even though I might not enjoy it (10: male, 16yrs).

I could see how a lot of things could go wrong and how it could bring me down but I've got this sort of outlook that it can't keep going on forever, something good will have to happen eventually and that will bring me back up and I could actually see a time where I went all the way down to actual depression (1: male, 20yrs).

Evaluating problems and the 'reasons' for distress

Interviewees also judged what they saw as the 'reasons' for their distress as a means of assessing whether or not this qualified as 'real'. It was the nature of the problem rather than the symptoms experienced that was important in making this assessment. Only 'extreme' and 'unusual' problems were thought 'bad enough' to provoke 'real' distress

while those more commonly encountered were seen as normal and relatively trivial. On this basis, most distress was normalised as common experience regardless of its manifestations.

You just think I'm really screwed up but that's OK, that's OK you know that's not so bad because yeah, everyone else has got it, you know, you're not the only one with coursework, you're not the only one with colleagues you don't get on with, you're just fine, just work through it (19: male, 23yrs).

I'm probably depressed but not manically or psychiatrically depressed because GCSEs at the moment so I just feel 'oh I'm going to fail' and get a bit depressed over it sometimes but nothing amazingly big (10: male, 16yrs, CIS-R=17).

In turn, this also meant that few problems were considered 'bad enough' to require or justify help-seeking.

I thought well maybe I'm just overreacting here, maybe I shouldn't go [to counsellor]... (LB: How do you mean, overreacting?) I mean just the way the situation was I might not have needed to talk to somebody about it. It was just a stupid thing anyway... (LB: Is it hard to know when you need to talk to someone?) Sometimes it can be hard. It depends on the person and what the situation is. I think it's a lot down to what the situation is because if it's something quite dramatic they might need to speak to somebody (20, female, 18yrs).

Even where 'real' distress was identified, this could still be queried and normalised by re-evaluating the reasons for it and evoking alternative explanations (above).

(LB: So you're not convinced you do suffer from depression?) No, especially now, I mean 'cos he [partner] left me [her 'reason' for depression] and he was the only person I loved, you know, I loved him enough to have a child with him and that did get me down (2) but don't people leave people all the time and they come through it? So yeah sometimes I think well do I really suffer from depression or is it just life gets me down, you know, it could just be everyday things (9: female, 23yrs, CIS-R=22; stopped taking medication and broke contact with GP).

However, what was considered a sufficiently extreme problem or event to cause 'real' distress was relative and changeable. Interviewees again disassociated themselves from 'real' distress by evaluating their own distress against examples of 'worse' problems or life situations. They subsequently concluded that they had relatively few or insignificant problems and constructed their life situation as incompatible with 'real' distress.

The more I see of the outside world the more I think I'm just whining about not a lot to be quite honest (19: male, 23yrs).

I've got a job, I've got money, I've got family, I've got relatively good friends and in that sense then I know I haven't got any problems. In another sense things have happened in the past and just things I generally think about,

they're my problems but they're not major problems, they're just my problems (12: female, 18yrs).

It's like my dad, he's been like diagnosed with depression but then...he was brought up as his mum was his sister (.) you know his grandparents adopted him so he calls his grandparents mum and dad and it's only just come out, the effects it's had on him all those years ago...you know so that is the difference....see, dad's got a reason to be depressed and I don't think I have you know... you know you've got depression if you've got a reason to be depressed (.) but I mean I haven't really, you know I got a beautiful girl and I've got a family that loves me...I've got everything what somebody would want (9: female, 23yrs).

Where significant life events or problems had been experienced, the point at which help was required could also be negotiated.

I've just been feeling quite down for quite a long time now. (LB: Oh right, have you got any idea why that is?) Umm just because of stressful events, which have happened over the past few months. I've had umm a few things at exam time umm within a month I found out quite a few really distressing things...(LB: At what sort of point do you think you'll have to get help?). I think it just has to be one more bad thing to happen to me now. One more thing to upset me and then I know that I can't cope with it any more (15: female, 18yrs).

Reasoning could also be reversed, using events to rationalise distress while locating 'real' distress with that which was unexplained or caused by biological dysfunctional rather than a life event.

I would think there was something really wrong with me if I felt this way and hadn't had bad experiences because I can justify it almost. (LB: Do you think you'd be more likely to get some help if you didn't know the cause?) Yeah, yeah, because then I would think there was something seriously wrong with me. (15: female, 18yrs).

Assessing distress according to images of help

Interviewees also assessed their distress by using images of help and help-seekers to consider whether their situation required such an approach. In keeping with images of 'real' distress to which they were closely related, images of help were also mainly extreme, involving hospitalisation and dangerous drug treatments. Inevitably, most interviewees came to the conclusion that their situation did not merit help-seeking and so was 'normal' and not 'real'.

I had read some stuff before when I was trying to work out if there was anything wrong with me. It was stuff about depression and nervous breakdowns and stuff and how you might have to go to hospital and I think that's what put me off going, not because I was afraid it would happen to me, but I just thought well that is proper mental illness and I'm not like that,

that's when you need medical help, so I can't need it, I'm not that bad so it must just be normal (23: female, 24yrs).

Outcomes of normalising for help-seeking

Definitions of distress impacted upon interviewees' assessments of their need for help since these were inextricably linked. 'Real' distress/ illness was thought to indicate a need for help, while for 'normal' distress this was not considered necessary.

Normalisation thus usually resulted in a decision that help was not needed or justified. Help-seeking was delayed (sometimes indefinitely) until distress was recognised and could no longer be rationalised and regarded as 'normal'.

(LB: I was just wondering why you think it took so long to go to the doctor, why do you think you left it so many months?) I think it's the same again. You don't want to admit to yourself that you're (.) I mean, you don't really know that you're ill in a sense. At the start I thought there's nothing wrong with you, you're just having a hard time, you know like that happens at college, and then as time went on I thought well perhaps this is something a bit more serious. And actually I went to the doctor's when it came to the point that I really did realise that something was seriously wrong (14: male, 18yrs).

I just didn't even think about it [seeking help] before, I just didn't even think for one second I need to see a psychiatrist (LB: What did you think you needed?) I didn't really think I needed anything. I just thought 'oh well this is how its gonna be and I don't like this' so I didn't really (.) it just didn't really click that I had depression. It didn't click at all....I didn't know I had a problem so I just left it and it got worse...if someone had said to me 'sounds like you've got a bit of depression, you can go and see' I would of thought 'oh help' and gone but I didn't know (3: female, 20yrs)

Normalised distress was constructed as a passing phase or transient experience for which help (particularly medical help) was neither required nor appropriate:

(LB: you still feel down from time to time?) Yeah but I wouldn't say it's anything out of the ordinary. I haven't come to live with it. I see it as something that a lot of people have, problems that a lot of people have, and there isn't really a cure for it, it's something that will always lurk at the back and that sometimes will come out but only being a small problem will go away again eventually (1: male, 20yrs).

They waited for distress to pass rather than seeking help.

I wouldn't have gone to the doctors then [without lay referral]. I just thought it [depression] was one of those things that time would heal (9: female, 23 yrs).

Where interviewees had normalised their distress by alternative explanations, these presented particular reasons why seeking help appeared unnecessary or inappropriate.

If distress was thought of as a personality trait, for example, this translated to a fatalistic belief that it was fixed and had to be accepted, and therefore was not amenable to help.

(LB: Do you think you'd find it (depression) easier to cope with if you did see it as an illness?) Probably I would. I'd be like, oh well it's a illness so you know like someone saying 'oh I've got tonsillitis' and they get help for it in the way of penicillin so it would be like the same sort of thing but I just don't see it as an illness. I just see it as like you have depression you just have it like you have blonde hair or something (LB: right so its part of you?) yeah, that's how I see it and that's why I think I'm never gonna get rid of it (3: female, 20yrs).

(LB: What did you think would happen in the end? Did you think it (self-harming) would just stop?). Um no, I suppose I just saw things staying the same. I thought it would just be something that I did. I didn't think it was good but I just thought it was going to be like part of my personality (13: female, 20yrs).

Distress linked to current stressors or life events and therefore rationalised as 'personal problems' was also thought to not require help on the basis that it would last until the problems were solved or life circumstances changed. Not separating the outcome (distress) from the stressor (life event) they believed symptoms could not be treated. This meant sitting out the duration until the problem resolved.

I think it is just a circumstances thing. It is what's gonna happen to me now. I think if I go away and go to University and get away from here and start again, I don't know, then I might feel better about myself (15: female, 18yrs, CIS-R=38).

(LB: So what can you do about those feelings [GHQ symptoms and suicidal thoughts]? Um, I don't know. I think once I've got my GCSE's out the way...I'm out of there [school] for good, it should change...I should hopefully be feeling much better. As far as I've decided it is all I can do is just to suffer until they're [GCSE's] over (10: male, 16yrs, CIS-R=17).

Where problems were considered solvable, because these were seen as personal, problem solving was thought to be something that could only be carried out by the individual concerned and so help-seeking – particularly from formal medical sources (chapter 7) - was dismissed as pointless or inappropriate.

If I've given it a name like my job or family then there's almost sort of no point in going [to GP] 'cos like could a doctor help me with my job or could he help me with my family I mean I see that as something I'd have to sort out (1: male, 20yrs).

Similarly, interviewees accepting their 'teenage angst' expected to 'grow out' of this, which was another reason for not seeking help.

I knew I'd grow up sooner or later...(LB: So you thought you had to sit it out?) Yeah, sit and wait. You think (.) you've got so many people saying 'oh, you're a kid, you don't know what you're on about, you'll grow out of it and that has stuck in my mind - 'you'll grow out of it' (17: female, 23yrs).

Attempting to make sense of distress was an on-going process and most interviewees moved through varying definitions throughout their trajectories. It was evident that several interviewees continued to find new explanations for distress to replace those that were exhausted and some past cases were able to reflect on this process. This prolonged the normalisation of distress, the inability to recognise need for help, and hence non-help-seeking for considerable lengths of time.

I looked at what was happening around me and I would try and attribute it to friends or something in the family or my job. I had to give it a name (.) I had to give it a reason (.) I could say 'well its my course, I'm not doing great in the course'...(LB: does it make you look at it differently then if you can attach a reason to it?) Yeah. (1) I'd think I hate going into college and try to focus more on improving what the course was like and things like that and expect it to to ease and if it didn't I'd root around and find something else to put it on (1: male, 20yrs).

At times, lay members input into this process. This acted as a social interpretation of distress and assessment of need for help and could perpetuate the process of normalising by reinforcing interviewees' own normalisations, causing those interviewees who had sought lay help to re-assess their own concerns about symptoms, and blocking lay referral of interviewees to formal help sources. Lay group normalising therefore could prevent help-seeking even when interviewees tried to initiate it.

When I speak to people about it, I don't ever really go into total depth about the way I feel but it's been 'well look at what you've been through, of course you're gonna be upset but you're not gonna for very much longer' and kind of trivialise it and then I come away thinking yeah, I'm just being over the top (15: female, 18yrs).

(LB: Did you consider seeing anyone professional then [after unsuccessful overdose]?) No because I mean my mum tried to help and said 'time will come when you've got loads to live for' and 'you're just being silly' so I didn't really get the opportunity to (12: female, 18yrs).

It could also prevent further help-seeking:

Most of the time I'll just sit in my room and cry or something. I don't talk to anyone about it. I mean I've tried (.) nothing against my mum but I've tried telling her before and she's said 'you've got no problems, you've got nothing to worry about, you're just being silly...I think that's why she thinks I haven't got any problems because well just I mean hormones and everything when you're a teenager (12: female, 18yrs).

Where distress was recognised, uncertainty about how to evaluate this led to inactivity, or non-attendance at follow-up appointments:

I didn't know what I was doing really. I didn't know if it was the right thing to have gone [to GP] at all... They [parents] certainly didn't encourage me to go back. It was not spoken about at all and if they'd said I should I suppose I would have. I just didn't know if it was real and if I needed treatment (23: female, 24yrs).

Interviewees wished to avoid the embarrassment of seeking help when this was not necessary:

(LB: One of the things we're trying to find out in this study is why people may not go for help when they're feeling depressed...) Well, I think the big one for me has been worrying whether or not it is the right thing to do, whether I actually need to, or whether I'm making something out of nothing or am going to look stupid (23: female, 24yrs).

They also wanted to avoid unnecessarily problematising distress that was not 'real' by seeking help as they thought this would make the situation worse and more long-term. This was thought to be a particular danger if formal help was sought and medication prescribed.

I did imagine going to see someone (help source) but then I imagined the problem almost becoming ridiculous by going to see someone about it (1: male, 20yrs)

If you go [to GP] and get anti-depressants and you really need them, then that's what you've got to do and so it's the right thing but if you don't need it and you go, then I guess it could turn it into something it needn't of ever been (23: female, 24yrs)

There was also a perception that help was not available for distress that was not extreme enough to qualify as 'real':

(LB: How long will you wait before worrying it's not going to go?) I don't know because I don't think I would go and get help from anywhere. There's people that can help you when you're on the edge like the Samaritans and people like that and if it got to a point when I was really ill then there's institutes and things that can help you but when you're in-between there's not. (LB: Oh right, so there's sort of things for when it's really severe but nothing for the stages in-between?) No. (15: female, 18yrs, CIS-R score 38).

The normalising of increasingly severe symptoms throughout the trajectory meant that the threshold for 'real' distress and a need for help was raised to increasingly severe levels of morbidity such as suicidal behaviour, 'hearing voices', 'nervous breakdown' or other crisis events. A small number of interviewees ('negative cases') were able to reflect

on this process. They reported not recognising that there was a problem for which they needed help until this was evidenced by a crisis. The criteria for 'real' distress and a 'need' for help then became when the crisis occurred and the individual lost control. This was also the point at which help could no longer be avoided and was usually enforced by others.

I just thought it'll right itself and then started hearing things and seeing things and it was like maybe not then (LB: But even then you didn't think you ought to go for help?) No...it's just really weird. That was all. But it wasn't ever scary until near the end (19: male, 23yrs).

(LB: So six months ago you thought it [depression] was just part of you and how life was at that moment?) Yeah (LB: What made you change your mind?) I changed my mind when I OD'd. (LB: So it was a turning point) um-hum (LB: Why was that a turning point?) Guess I actually realised the seriousness of it, like taking your own life is pretty serious (16: male, 19yrs).

I was really badly like depressed, I was about seventeen, yeah and I didn't go to the doctor's because I didn't think that it was um (.) oh well I didn't think I was ill. I didn't think I was ill so it ended up that I ended up in hospital [overdose] and then, only then, did I find out that I should've gone to the doctors but I didn't know beforehand, I had no idea that I should have done that...I really needed to see myself there was a problem. I think that was the hardest thing ever to actually realise. I mean it took me to go into hospital to realise (3: female, 20yrs).

The inevitable outcome of normalising and non-help-seeking was that interviewees struggled to cope alone with, sometimes severe, morbidity.

I'm just getting on with it for the time being. Unless I wake up one morning suicidal that's when I know that I've gotta change and I've gotta get help, some more help, at the moment I'm just gonna plod along in the same little wavelength that nobody really understands what I'm on about (5: female, 22yrs)

Meanings of help-seeking and avoidance of help

The previous section described the difficulties interviewees experienced in defining their distress and how their usual response was to normalise distress and therefore not seek help. It was indicated that their uncertainty about symptoms was perpetuated by a reluctance to arrive at a definition of 'real' distress. This section will explore reasons evident in interviewees' accounts for this reluctance and which may motivate normalisation. Central to this is a description of the meanings attributed to help-seeking. Interviewees assigned help-seeking the main role in officially and publicly defining distress and thus locating this within their polarised framework of normal and 'real'.

There were two ways in which help-seeking could define distress – each with undesirable outcomes. First, it could open one’s distress to public judgement and result in an assessment by the help source and others that the distress was not ‘real’ thus subjecting the individual to the stigma surrounding non-genuine distress. Second and conversely, help-seeking could define distress as ‘real’ – not least because ‘real’ distress and the need for help were inextricably linked (above). In fact, interviewees believed that help-seeking transformed the nature of distress. It was regarded as a pivotal act that transferred the individual from ‘normal’ distress across the threshold into the category of ‘real’ distress. As such, help-seeking was believed to initiate a status passage from which a number of undesirable outcomes would follow, in particular, the stigma of mental illness. Stigma thus emerges from help-seeking in two opposing ways: suggesting hypochondria or diagnosed mental illness. Avoidance of stigma was integral to avoidance of help-seeking. Discussion of these issues here is mainly general and chapter 7 elaborates upon their association with specific help-sources.

‘Making distress real’ - transforming the status of distress

Interviewees believed that help-seeking would transform the entire nature of the distress that they experienced by ‘making it real’. There were a number of ways in which they suggested it could do this but these essentially referred to a loss of personal control over the distress. Some interviewees believed that help-seeking would make ‘normal’ distress worse. They associated help-seeking with ‘giving in’ rather than ‘fighting’ distress, and with surrendering the control over distress which allowed them to limit its severity. These interviewees preferred to ‘cope’ without seeking help, believing that by doing so they could maintain control and resist their distress becoming ‘real’.

If I stopped then [to get help] and gave in then I couldn't imagine ever being normal again. I really wouldn't have to bother anymore, it'd be the sort of point of giving up I suppose, or giving into it. I could just stay in bed and give up and then it seems like I'd be going with it rather than fighting against it... I could even say to myself well you can't help it because they [doctors] said you're depressed (23: female, 24yrs).

Personal control also meant the ability to hide or deny to oneself or others the ‘realness’ of distress and therefore to avoid this definition. Help-seeking however, was seen as removing this ability and demonstrating or confirming the ‘realness’ of distress by enforcing an official diagnosis or label, and turning private experience into public

reality. In this sense help-seeking was avoided where interviewees were fearful about what their symptoms indicated and their possible repercussions.

(LB: Can you think of any other reasons that might put you or anyone off of seeking help?) I think if you went to somebody professional, I think that it might put you off because it would be like confirming there's something wrong with you, and I think that it's scarier to find out that you have got a mental illness or something like that rather than a physical one. I think it would scare me if I did go to somebody and they said that I've got proper depression and I need to go on anti-depressives. I think that would scare me. (LB: Because it would make it seem more real?) Yeah, or that I would end up in a nut house (15: female, 18yrs).

It's [help-seeking] like going to authority and saying (1) that just didn't seem the natural thing. I was in denial so. (LB: When you say authority, do you mean the doctor?) Yeah. (LB: Can you tell me a bit more about why you didn't want to see someone in authority?) I was frightened of admitting what I had...it would have been like it was more out in the open. It would be (.) real. It's mainly to do with that 'cos I was in denial. I didn't want it to be real (2: female, 19yrs).

In this respect, many interviewees therefore conflated help-seeking with an act of admission or confession.

It was like confessing all these things I'd not told anyone like he [GP] said 'do you feel suicidal' and I said sometimes and I thought you know this is real, I'm really saying this. It was a big step. I can't really explain it but I think you have this image where you might go to the doctor for something physical when it's really quite minor you know like your sore throats or whatever but if you go for something mental it is because it's got so bad (23: female 24yrs).

Help-seeking would also make distress 'real' or 'more real' because it would problematise it.

I felt that it was my problem and if I talked to anyone else that would make it a bigger problem and I was trying to hide it, I was trying to push it away, trying to get rid of it (LB: Why did you think it would have made it a bigger problem if you'd told someone?) Because people would always wanna talk about it, people would always wanna bring it up and I'm trying to forget that, I'm trying to get rid of it, so I didn't want to ask anyone for help (3: female, 20yrs).

This was particularly the case where formal help-seeking was concerned. The association of distress with help itself implied a particular level of severity and transferred distress from normality to 'realness' because, as described above, the receipt of formal help was regarded by interviewees as a criterion for identifying 'real' distress. The response of formal help-sources was thought to remove any hope of normality through sick leave, referrals, public exposure of distress and undesirable treatments

(below). This was a particular issue for interviewees who were unsure whether their distress was in fact 'bad enough' to warrant such a response.

If you went to a teacher or counsellor they could refer you to your doctor and that could have bad repercussions..(LB: Can you imagine going to your doctor could make it worse?) Yeah, yeah in a way that he could over dramatise things...he could say 'yeah, you're depressed, you're gonna go on anti-depressants and you're gonna go to counselling and we're gonna send you to a psychologist and we're gonna tell your mother and tell (.) (LB: So it could turn it into a bigger problem?) Yeah I think so (15: female, 18yrs).

In this context, non-help-seeking was regarded as a means of maintaining normality.

I got to a stage where I saw that it could go either way. I could take time off work and start seeing a psychiatrist like he [GP] suggested but if I did I imagined that I would grind to a halt forever and it would become really serious and my family would know all about it and there'd be no turning back or if I didn't I could just try to keep hold of being normal as far as I could and keep my life slowly churning along and try to get over it and that's what I decided. I saw it as the best thing I could do really if I ever wanted to come through it without it changing my life forever. (23: female, 24yrs)

Help-seeking as an irreversible status passage

Interviewees perceived the transformation of their distress into distress that was 'officially real' as highly significant and negative. This was evident from the expressions they used to describe this process, for instance, 'going deeper', 'a dangerous point', 'a new dimension' and 'no turning back'. Ironically, the underlying concern was that help-seeking would make the distress either long-term or permanent rather than offering the prospect of cure or recovery by initiating an irreversible status passage that entailed a number of undesirable outcomes, namely, a public change of identity and frightening, disruptive treatments, and which therefore removed them further from normality.

Interviewees wished to deny that they were a 'person with 'real' distress' and to avoid or delay initiating this status passage:

The more people that know...you really do have to live with it because its like you become that person and there is no means of escape and so until you are 100% sure that you are like that [have 'real' distress] you just don't want to become it...I wouldn't want to make a big fuss or have other people make a fuss in case it was a false alarm (23: female, 24yrs).

The change of identity was represented through becoming a patient and receiving treatment, which reinforced the need to avoid formal help and some explicitly described how they adopted 'coping strategies', including self-harm, as a means of avoiding help and therefore this status passage.

I didn't know what to do or where to go but then again at the time I thought I was doing the right thing. I thought harming myself was the right thing, it was my solution, my way of coping with things and keeping things going rather than going somewhere for help 'cos that's what I wanted. I wanted things back the way they were beforehand so I wanted to try to keep things normal and to keep sane. (LB: Keep sane?) Yeah, its like another person might just have another drink – think oh that's alright I'll have a drink and everything will be alright. I wanted it to be alright. I didn't want to have to take a backwards step, to get help (LB: to seek help makes things not normal and makes you insane?) well it's a sign that its got to this extreme and things aren't gonna be just normal anymore (13: female, 20yrs).

[Respondent provides long narrative of her attempts to 'cope']... (LB: but is that the only way? I mean can't you be helped with feelings like that?) I'm not really sure, I mean yeah, there's always anti depressants or whatever (LB: So what makes you try your approach rather than that?) Well with my approach I'm trying to avoid that, well not specifically antidepressants just like the whole thing of being treated for depression...because once you go outside and get some sort of help or treatment it changes the whole thing. The feelings might not change but suddenly its like official you know and that just makes you view the whole thing so differently and it makes it seem more real and permanent. I mean you can't exactly think oh yeah its going to go tomorrow and I'm going to get rid of this and all that because now you're a patient or whatever, you're being treated and oh I don't know how to put it. It's almost like before you could have escaped it but once its official you can't and you have to be a depressed person because you've said you are and the doctors said you are and you can't try to convince yourself otherwise or leave it behind... It is a big thing to do. It makes it much bigger and real and so then it's harder to escape from especially if it means other people then know about it. You can't just keep it as your secret then (23: female, 24yrs)

It was thought that treatment itself would lead to public exposure of the distress and that receiving help for 'real' distress would result in a permanent and social record of disorder and treatment that would persist even if recovery was made.

I find it hard to imagine recovering from it [depression] because I would be like different forever because everyone would know and would be watching me in everything I did...I think just that it's not as common place and temporary as going for something else like a sore throat or something...going for any mental health thing seems more like getting some kind of special mark put on your record (23: female, 24yrs).

Interviewees listed several possible repercussions that could stem from acquiring this new identity and 'record'. These included employment problems, children being taken away, and being unable to emigrate. These were further reasons for not seeking help.

Officially transferring to the category of 'real' distress also had a number of consequences for the individual's identity on a personal level. It involved grappling with the meanings associated with 'real' distress such as stigma (discussed below), weakness and other negative traits attributed to those who become distressed (above).

This required many to reassess their character and identity and several struggled with this, not perceiving themselves as the 'type of person' likely to suffer mental disorder.

(LB: Were you surprised when you started to have these feelings?) Yeah, because I've always thought of myself as a really strong person...I'm supposed to be tougher than that. (LB: What sort of image do people have of someone who gets depressed?) Somebody with not a strong character, not a strong personality. Low self-esteem. A quitter. (15: female, 18yrs)

Although these themes were mainly discussed in relation to help-seeking from formal help sources, it was thought that similar issues would apply if problems were disclosed to lay sources – especially parents – since this would also entail a spoiling of identity and interviewees thought they may be forced to take further action (such as seek formal help), or have their behaviour monitored.

Treatments

The prospect of receiving treatment was a particularly undesirable outcome of having distress officially categorised as 'real' since interviewees had negative images about what treatment for mental distress entailed. This was cited as a reason for avoiding help by most interviewees. Fear of anti-depressant and similar medication was widespread (Chapter 7). Just as 'real' distress was an extreme and stigmatised category in their polarised framework of distress, interviewees' corresponding images of 'help' were similarly extreme. They feared that seeking help would lead to 'being sectioned', and going to a 'mental home', 'nuthouse' or 'asylum'. This had further implications for their identity and they feared the seriousness, stigma and disruption that this would entail:

You put someone in a very difficult position if you do that [disclose feeling suicidal] aside from which then they might whisk you off to some asylum or something when all you wanted was some support and understanding, not to have your life suddenly changed (23: female, 24yrs).

(LB: what might 'help' have suggested to you?)...like a a home or somewhere as soon as they said help automatically just like my mum used to say stuff like 'oh there's that freak on TV she's been in a mental home' and I'd just be like 'oh my god' you know so no I would've been like 'no I'm not going in'. My mum would've just been like 'shit' (3: female, 20yrs).

These extreme images of help led interviewees to believe that treatment would cause considerable life disruption. They believed treatment would be long-term and pervasive, causing further departure from normality. They contrasted this to treatment for physical conditions which they perceived as being more contained and curative. These views further reinforced the wish not to seek help.

Stigma

The undesirable outcome of help-seeking that featured most prominently in the majority of interviewees' accounts was stigma. This underlay many of the fears surrounding definition of distress as 'real', identity, and treatment. It was also relevant to the opposite outcome of help-seeking – dismissal of distress as non-genuine. Interviewees wished to avoid three types of stigma: 1) of having 'real' distress (mental illness) signalled by need and receipt of help, 2) of weakness, badness and shame associated with help-seeking per se and being distressed, 3) of being a hypochondriac or being 'non-genuine'. The strong desire to avoid stigma led inexorably to a failure to seek help.

The stigma of 'real' distress (mental illness)

A main reason why interviewees wished to avoid 'having' 'real' distress was a fear of the stigma associated with this (above). This stigma was damaging to self and social identity and was thought to lead to a range of undesirable outcomes including being abandoned by family and friends, ridiculed by peers and being sectioned or subjected to frightening treatments. Not seeking help was a key strategy for protecting one's identity and avoiding these possibilities since, as described above, interviewees regarded seeking help as the act that would locate them officially in the category of 'real' distress and expose this to others.

The avoidance of stigma influenced illness behaviour on a number of levels. In the first instance, it led to denial which compromised some interviewees' willingness to recognise their problems or to define themselves as in need of help. They did not want to see themselves as 'screwy', 'nutty', a 'freak' or 'not normal', though several feared that they were.

I tried to deny it [depression] because I just wanted to be normal like everyone else (LB: Oh right so you thought if you admitted you had depression you wouldn't be?) yeah I'd just be inadequate (16: male, 19yrs).

Everyone says if you have depression they say it's a mental illness, it's like, you know, 'you're a freak' so I thought no I don't have that, I thought, I'm not a freak, but I felt like one (3: female, 20yrs).

Avoidance of stigma was also a major driver of interviewees' wish to normalise their condition:

[Respondent describing an episode of depression] (LB: do you think that you were ill?) No. (LB: no, you don't see it as being an illness then?) (5) well I

didn't ahh I didn't think I was physically ill I mean I knew I was mentally (.) I didn't think I was mentally ill as such I just thought (1) mentally ill for me is like (1) that gives me like a picture of someone who's really screwy in the head mentally ill, mentally ill, it depends how you define mental illness I suppose (LB: um-hum (3) so how do you think it would have been right to define what you were going through?) Just a normal cloud of (2) something I don't know I wouldn't call it mental illness (7: male, 17 years).

Fear of stigma surrounding mental distress also prevented interviewees from talking to others about their feelings and symptoms. Most regarded mental distress as a taboo subject and so felt unable to address this with friends and family. Suicidal thoughts and self-harm in particular appeared to be 'unacceptable' things to talk about. Several believed that if they did they would be regarded as 'mental' or similarly stigmatised, and one respondent (*i.d.* 20) had resorted to writing to a friend about feeling suicidal being unable to discuss it directly. Some interviewees had experienced such reactions.

Some people think, that if they've ever contemplated suicide that you're completely off your head (LB: do you think lots of people think that then?) Yeah, I think so. I mean if you ever say anything to anybody about 'oh yeah, tried to commit suicide' they think you're mental. I've told somebody before and they just looked at me as if to say 'whaaaat?' (12: female, 18yrs).

The same was true of talking about suicide to a GP or other health professionals:

I can't even imagine telling someone I wanted to kill myself, you just don't do it, you don't say things like that. When I said yes to the doctor's question it was like some dirty confession. It's like a bad secret and you keep it to yourself (23: female, 24yrs).

Interviewees instead tried to conceal their distress fearing that otherwise family, friends or peers may withdraw, discredit, or even ostracise them. This meant not seeking lay support and sometimes isolating themselves from others so that distress was not discovered. Again, several recounted instances where they had been stigmatised when their distress was revealed.

(LB: Why were you trying to conceal what you were doing [self-harming]?) Because, I knew what would happen. It sounds really really weird but even though I guess you know kids growing up faster and so many external stimuli and all the rest of it, you think people might have an idea of this but people my age just totally, you know, they just ostracised me you know I was persona non grata there. It it wasn't like oh wow [respondent's name] got a problem he's needs some help, he's in trouble there, it's like oh my god he's such a psycho, oh he's a freak get rid of him and all the rest of it yeah yeah so. (LB: So it was fear of stigma?) Yeah totally and it was borne out, I was right you know... man I got such a roasting (19: male, 23yrs).

Stigma also interfered directly with interviewees' willingness to seek help. Due to the inseparable association they made between help and 'realness', interviewees thought that being seen to need, receive or ask for help for mental distress would necessarily define them as having 'real' distress and the stigmatising labels associated with this extreme category would follow. These included 'nutter' / 'nutcase' (i.d. 13,5,10,15), weird (i.d. 3,14,20), mad (i.d. 5,17) abnormal (i.d. 16), 'do-laa-lee' (i.d. 22), freak (i.d. 3,20), insane (i.d. 10,18), screwy (i.d. 7, 10).

Stigma applied if help was sought from informal or formal sources but needing formal help was the greatest sign that they had moved over the threshold into the extreme category of 'real' distress and by implication would/ had become a 'freak' or 'nutter'. This was particularly the case if GPs prescribed medication or made referrals:

My school sent me to some [counselling]...(LB: What did you think of that?) I thought 'no, they think I'm a nutter, I don't want to go' (10: male, 16yrs).

(LB: What did you think about being prescribed the anti-depressants?) I thought 'oh no, now I really am a weirdo', that is what I thought. I thought oh no, but I thought no if they're gonna help me, no-one has to know (3: female 20yrs).

Denying or attempting to re-negotiate need, and/or refusal were means of avoiding help where interviewees thought they would be stigmatised for obtaining or accepting it.

I thought no:o I said to him [GP] I don't want to see one [psychiatrist] and he said 'but I really think you should' and I thought oh my God I'm gonna be such a freak, I did, I don't want to see a psychiatrist I thought. I said to him [GP] I can sort this out on my own...(LB: Did you really believe you could?) No, I thought there's no way I can but I thought you know anything rather than seeing a psychiatrist (3: female, 20yrs).

Others had considered seeking formal help secretly, or had tried to do this, in an attempt to avoid the public labelling and judgement otherwise anticipated.

If I go really down I will go and get some help and people say to me 'you're a nutter' I'll say 'yeah whatever' if I even tell 'em, you know, I might just 'ah well what they don't know won't hurt 'em'...(LB: So you feel it's something you need to hide?) Yeah, I suppose, for a quiet life (9: female, 23yrs).

Moreover, at times, many interviewees simply did not seek help at all, despite considering they needed to and that it might be beneficial, in order to avoid the anticipated stigma. Non-help-seeking was a means of preserving their social identity and ensuring they were not estranged from friends, family or peers.

I thought I was [a freak] but I didn't want to be because like everyone puts a label on it everyone like labels it as you know mental illness, oh my gosh you know you're not normal and people label it, and they shouldn't but they do and I didn't wanna come in that label (LB: so do you think if you'd sought help you would have been labelled that way?) That's what I thought yeah that I would have been labelled as you know like a weirdo and 'oh there's that girl she's really weird' and that you know I just I thought to myself that's what I would be, that's the label it has (3: female, 20yrs).

(LB: why might people not seek help?) Probably because they might get labelled by society because everybody's got to have an image...if they don't have this image then they'll get looked upon as weird by society..and you might not want to go to your counsellor because people might think 'oh, he's a bit strange' and so people start talking and keeping their distance and then you become alienated and it's a lot harder that way so I think most people wouldn't go because of that, I mean that's possibly why I don't do it. I mean if everybody's gonna start taking the mick out of you or ignoring or staying away from you because they think you might be a bit nutty then I don't particularly want to go through that, I'd much rather be a bit depressed now and again and have all me mates around me rather than go to a counsellor, get everything sorted, still feel a little bit depressed and have everybody kind of stay away from me (10: male, 16yrs).

Several interviewees were particularly concerned to hide distress from their parents fearing their reactions. This also resulted in attempts to conceal treatment or refusal of formal help.

When my doctor suggested to me I see a psychiatrist or community psychiatric nurse, that was one of the first things that went through my mind actually, you know, I can't do that, how would I tell my Mum? (23: female, 24yrs).

I didn't tell her [about GP referral to psychiatrist] 'cos I thought she would be 'oh, you're insane like your dad...I worried too much about what other people thought and I shouldn't have (3: female, 20yrs).

A smaller group of interviewees also feared being stigmatised by professionals, from whom they might seek help – particularly GPs – and the possible consequences of this, which included being judged, labelled and sectioned.

I just didn't think about speaking to the doctor because I didn't want to be sectioned or anything. You know there is a stigma about psychological health. There's like this black, black cloud and as soon you know you sort of fall under it then everyone else just runs for cover. That's the way you know it's like in society certainly my experience, why should reality be any different really. Why should anyone else in like sort of a professional position take it any other way. I thought if I said anything to, something, to anyone I mean, I thought I was going to end up at [local psychiatric hospital] or something having electric shock treatment (19: male, 23yrs).

Issues surrounding the potentially damaging effects of help-seeking were seen by most interviewees as particularly important within the context of young adulthood due to the

importance of 'image' and the tendency to stigmatise was especially attributed to peers. Above all, stigma applied to young males and their peer groups due to social norms about emotionality. A specific account of stigma within the lay network and its affects on help-seeking is provided in chapter 7.

(LB: Would a girl going to a counsellor be seen as a nutter?) I don't think so. I think it's more just the fact that they're a woman. I look upon it that girls find it so much easier to talk about their problems than blokes do. A bloke shouldn't really have any problems, they should just go out earn the money...but there are slightly deeper feelings than that and a bloke has to try to conceal them...even though it might hurt them inside they still have to because otherwise society looks upon them as being weird and kind of stays away from them (10: male, 16yrs).

The stigma of 'real' distress/ mental illness was seen as difficult to escape even after distress had passed and was therefore regarded as a considerable risk that would not be taken except in cases of extreme necessity and without considerable 'nerve'. This was particularly the case where interviewees believed help-seeking only had limited possible gains (chapter 7). Stigma therefore was a major barrier to seeking and obtaining help.

(LB: what could be done to encourage people to seek help?) If other people knew and understood. Well not even understand but had had an inkling that something was up and that it didn't mean that you were a psycho...you just want people to think well there's something wrong there so I'll tell myself to shut up and let him sort himself out or point him in the right direction without me going over to him and saying he's a psycho and like screaming and saying shit about him and stuff you know because that's what happens. (LB: So if you removed the stigma people would find it okay to go for help?) Totally, I mean without stigma where's the fear? You know if people aren't going to go round saying 'that bloke, he's slashed his arms, he's screwed in the head' but someone will say 'he's doing that and that's not right, I think we ought to call the occupational health bloke and have a chat and tell him we're behind him and hope he gets through', you know, well where's the problem then? (19, male, 23yrs).

Other stigmas of help-seeking: weakness, badness and shame

Interviewees were also concerned about other negative meanings of help-seeking and having distress. These centred round weakness, badness and shame. Many interviewees regarded help-seeking as admitting defeat, an inability to cope, and therefore weakness. These feelings could exacerbate the low self-esteem that often accompanied distress. Interviewees therefore saw help-seeking as a failure on both a personal and a social level. This also could mar their identity and was a further reason why they tried to 'cope' without seeking help as long as possible.

It's a hard decision [seeking help] to take anyhow. For me going for help was just a sign of weakness so it just made me feel even worse for a while so... (LB: Did you ever worry what they [friends] might think?) mm-hum. (LB: What did you worry about?) That they might think I was weak, um pathetic, abnormal basically, just weak and different (16: male, 19yrs).

Such ideas created a widespread obligation amongst interviewees to resolve their mental problems alone. This was particularly the case where they considered themselves to be to blame for the problems causing their distress (below).

Its just something that's been ingrained to me that you shouldn't go and seek for help, you should try and battle it yourself I suppose. Its just something I've I don't know, a learnt response or something I don't know... (LB: Even if it might take longer or you feel worse?) Yeah (16: male, 19yrs).

If you've got a problem you're kind of expected to sort it out yourself and to be strong enough to hold yourself together and just carry on, but I think if you go to somebody [for help] it is just like giving up, I can't cope with things. (15: female, 18yrs).

This affected illness behaviour, reinforcing avoidance of help and the struggle to manage without.

I thought, right I'm gonna try and do this on my own then it proves I'm a stronger person, I can beat this, you know, it's not gonna beat me and so I weaned myself off [prozac] slowly (9: female, 23yrs).

The manifestations of distress itself, for instance, tearfulness, were also taken as signs of weakness and their existence would be confirmed and exposed by seeking help. Most interviewees, male and female, thought this was particularly problematic for young men due to social norms emphasising a macho image and discouraging help-seeking and emotional expression, particularly within their peer groups, while the same expression was more acceptable if not expected in females. Male interviewees described how they had been prevented from help-seeking by such norms.

(LB: Is it easier for women to seek help than men?) Yeah, it has to be. Women are looked upon as very sensitive and they can cry so much easier than a bloke. A bloke has to be the macho man and keep a straight face all the time, can't cry in public otherwise they could get killed....women are expected to cry almost whereas blokes, you do not cry in public and if a woman can cry in public they can obviously seek help a bit more (10: male, 16yrs).

Seeking help also meant that the causes (eg. life events) and existence of behaviours associated with distress, such as DSH, were exposed. This was problematic where these events or behaviours themselves were viewed as examples of badness or shamefulness, or where they were regarded as private. In such instances, interviewees thought they

would receive condemnation from parents, peers or professionals if they attempted to obtain help. Non-help-seeking was therefore a means of concealing shame, avoiding judgment and guarding privacy.

I thought I was bad for not sorting my problems out.. I thought I deserved to cut my arms. It's hard to explain but I did. I thought I was bad and so that's why I didn't want to go to others about it (13: female, 20yrs).

(LB: Did you speak to your family [about depression]?) No 'cos I think I brought all the depression on myself now (.) now I know you can't do that but that's how I felt. I thought it was all my fault in any case, I was a waster (LB: Is that what you thought they might say to you?) mmm, sort your life out yeah...but now I feel the opposite I feel as if I could tell anybody everything that I feel I need to tell them. (LB: what do you think's changed then?) 'Cos I'm not ashamed of what I done now (5: female, 22yrs).

This occurred where interviewees saw the blame for distress being located with the individual and so the fact they were distressed reflected negatively on their character. They contrasted this to physical illness which they argued generally confers victim status and does not imply anything about the individual so help-seeking does not present the same difficulties.

If I broke my arm people would say 'man that's really tough luck, go get it sorted out'. So it's bad luck rather than you being screwed in the head or something and just being a psycho. I mean you don't see Hitchcock movies called 'Broken Arm Man' do you? They're all called 'Psycho' and things like that (19: male, 23yrs).

Exceptions to this were intimate complaints and AIDS. Three (*i.d.* 10,15,16) interviewees assimilated the stigmas of badness, shame and blame associated with AIDS to mental distress. These stigmas were reasons to hide distress.

If I said I had AIDS then people would have the idea I must be a junky, or if I was male I must be gay or that I'm a slag...and its just something that has got so much stigma around it wouldn't be worth telling anybody and it would be the same if I turned round and said I've got proper depression. Then it would be, 'I bet she was abused as a kid', 'I bet she's tried to hang herself twenty times (15: female, 18yrs).

There was some indication that whether or not stigma arose from help-seeking for mental distress depended on the cause of this distress. If this was a severe life event that 'happened to' the individual, help-seeking was more likely to be acceptable and interviewees felt more inclined to seek help.

If you're going to counselling sessions that's probably because you've got a problem and there's something wrong with you so you're probably a bit screwy or something to need counselling but if you're going 'cos you've just been

raped or something then that's a different matter. I mean if you've suffered something which needs counselling to help you come to terms with it then that's bearable (10: male, 16yrs).

The stigma of non-legitimate distress and help-seeking

While interviewees wished to avoid the stigmas associated with having 'real' distress and seeking help for this (legitimate help-seeking), stigma was also associated with seeking help for distress when it did not qualify as 'real', or when others did not consider it 'real'. This stigma involved being perceived as a hypochondriac, or as melodramatic, attention-seeking or non-genuine, and was realised through what was considered to be 'non-legitimate' help-seeking.

Fear of the negative judgement and reputation associated with non-legitimate distress and help-seeking appeared to underlie some of the concern about whether distress was 'bad enough' to qualify as real which characterised interviewees' attempts to evaluate their distress (above). The risk of being criticised for seeking help for 'normal' distress affected assessments of need by reinforcing the need to make sure distress was 'bad' and 'real' enough before seeking help:

You sort of want to be sure you are ill before you go 'cos if not its like you've gone for nothing. But especially with depression, it just seems if you go and claim that's what you've got and you haven't that would be like, I don't know, really melodramatic. (LB: Why especially with depression?) I don't know. Maybe because of what we were saying before about everyone getting a bit depressed. You'd look a bit stupid and weak if you just had what everyone else does and copes with but then you make a big deal of it and see a doctor (23: female, 24yrs).

Other people, not being in the position, don't understand why you're feeling how you're feeling and don't see psychologists or counsellors as being people who could actually help. I think they'd see it as being a bit melodramatic and that is why I don't think I would tell them, more, it would be one of the reasons why I wouldn't go [for help] (1: male, 20 yrs)

The same applied to the 'problems' that might cause distress and for which help might be sought. Several interviewees had not sought help because they did not consider themselves to have a 'proper' problem for which they considered help-seeking was or would be regarded by others as justified.

It [seeking help] would have been further down the line for me..I think maybe losing someone very close to me would perhaps sort of push me over the edge or something or push me further in that direction and then I'd see it as I'd have something worthwhile to go with...I wouldn't feel so bad for actually seeking some help 'cos I'd feel like yeah that's a proper problem, I can go and see

someone about that and if other people around me saw that I was feeling bad, feeling down, they would attribute it to 'oh he's lost his Dad or his friend' or whatever and 'that's why he's feeling so bad and that's ok 'cos that's terrible' (LB: so there's certain things that it's okay to feel bad about and get help for?) Yeah there's a list of (.) there's a set of things you can feel bad about. Sounds ridiculous! But I think as far as reasons go it's less embarrassing if you've got one of the proper ones (LB: it would be embarrassing to seek help otherwise?) I think I would be embarrassed at first I'd go in feeling bad and I'd be worried that I was gonna explain my problems and that the person would not actually tell me that I was being stupid but would sit at the other end of the table and think this is ridiculous you're letting this get to you and they would point to like a personal trait of mine for blowing things out of proportion...a weakness I have or just a tendency I have to exaggerate and self pity and things like that (LB: did that cross your mind when you considered seeing a counsellor?) that I was blowing things out of proportion? (LB: yeah or that they wouldn't think you should be there?) That was something that crossed my mind and I'd put myself in that position and thought well if someone came to me with that problem I would say they were blowing it out of proportion (1: male, 20yrs)

In addition to the reputation they could get for non-legitimate help-seeking, interviewees also feared the negative responses, accusations and embarrassment they believed would follow from seeking help if others did not consider their distress to be legitimate. They linked a series of negative social attitudes to non-legitimate distress and help-seeking, for instance, that the person should simply 'pull themselves together' and 'get over it'. In particular, they feared dismissal by help-sources rating their distress as 'normal'. Their fears were exacerbated where they had previously been dismissed or had watched this happen to others. The desire to avoid these responses also caused them also to avoid help-seeking as a means of protecting themselves. They attributed these responses to lay sources and also healthcare professionals and therefore avoided help-seeking from both.

Interviewees feared that friends and family would become annoyed, impatient and dismissive if approached for non-legitimate distress or problems, and that that this could result in the help-seeker being regarded as 'stupid' or 'weak', accused of being ungenune or 'faking it' (i.d. 21) and, as a result, relationships being compromised.

(LB: Did they [family] know about that [respondent's suicidal thoughts]) I don't think they did at the time but I told them eventually. (LB: Why didn't you tell them at the time?) 'Cos they probably would have thought I was being stupid and over-reacting (20: female, 18yrs).

Trying to sort it out myself I'd be less worried about other people becoming annoyed by it, which I could see happening if you were constantly down, then people would question why and if they couldn't see a reason anymore then it would start becoming annoying to them, so simply out of not wanting to annoy other people and perhaps lose some friends or have people talking about how stupid I was being I would try and sort it out myself (1: male 20yrs).

It was feared that healthcare professionals would complain about time wasting and would be unwilling to help.

I wouldn't have gone to my doctor for any specific reason, I don't think they could have helped me because the issues I faced [parents' divorce] I think they would have just kind of looked at it and gone 'oh everyone deals with that, get over it' kind of thing you know...I think they'd sort of go 'tut, well it was a bit of a small problem anyway you know so why are you here?' (13: female, 20yrs).

Adding to these difficulties there was a sense that in society, most mental distress is not considered legitimate, and that social recognition and legitimacy is much more difficult to obtain for mental compared to physical complaints. This explained other common attitudes such that mental distress is 'all in the head' and 'put on' and meant that non-help-seeking occurred even when interviewees did believe or suspected their distress was significant because they thought it would not be perceived this way by others.

I think a lot of people think people with depression are hypochondriacs. I think a lot of people don't actually think there is such a thing as a psychological illness or disorder, yeah obviously things like schizophrenics and things where there's chemical imbalances and people can see there's a problem but I don't think people take eating disorders and depression and things seriously at all. People just think it's either a teenage fad or something everyone goes through, it's just that some people get more over the top about it (15: female, 18yrs).

Some even attributed such attitudes to their GP:

(LB: What did you think your doctor might do?) Well to be honest, I thought she might laugh at me, I mean I know that sounds stupid but like I said, even a doctor may not necessarily understand depression. There might be some doctors who don't really think it's an illness. There's a lot of people who don't think it's an illness (14: male 18yrs).

Young adults' distress and legitimacy

Issues surrounding legitimacy appeared to be even more pertinent in the context of young adulthood. Most interviewees believed legitimacy was more difficult for young people to obtain due to widespread beliefs that young people do not have 'real' distress and that the legitimate 'reasons' for distress are confined to older adulthood (above). They also cited the ease with which young people's distress could be normalised by others, for instance as 'exam stress' or 'teenage angst' (above). They believed that this increased the likelihood of being accused of non-legitimate help-seeking which, in turn, increased their avoidance of help.

Many interviewees had thought that their distress would not be taken seriously but stereotyped and dismissed as 'teenage angst'. This deterred them from talking about distress and seeking help in case they were turned away.

That I think is a major thing it's [DSH] just so difficult to talk about and it's a big problem for young people (LB: self-harm?) Yeah people all go oh that's teenagers and a bit of angst and that's part of listening to heavy metal and you're just being stupid, just don't do it, grow up a bit. Its got this image its just most people think oh grow up. But it's not like that. (LB: So people don't take it seriously then?) No, not in a big way (13: female, 20yrs).

(LB: Given that you were obviously feeling suicidal at the time, did you think you needed some help?) No. I didn't think anyone would listen to a 15/16 year old. (LB: Do you think age is important then?) Yeah. I think a lot of stress in teenagers get put down to they're growing up. You get told 'that's all part of growing up, that's all'. I heard that one so many times. 'It's all part of growing up, it'll get better when you are older (17: female 23yrs).

One respondent suggested that gaining legitimacy was a particular difficulty for young females, though acknowledged that for other reasons, young males may find it more difficult to actually ask for help.

Society's idea of women is that women are a bit over the top about their problems anyway, they're always whinging about something and don't really take it seriously. If a woman's really upset and is crying and acting strangely, then you can put it down to PMT or something. Whereas with a guy then it's usually something more serious if a guy starts to cry, then there is something pretty wrong with that guy in society's eyes because it's not acceptable for him to do that. For a woman it would be she doesn't need any help, she needs a bar of chocolate and her girly mates to come round for a night, whereas if he's upset then he needs to seek help from somewhere but that's just me talking about young males and females (15: female, 18yrs).

Several interviewees had directly experienced such difficulties when attempting to obtain informal help and so avoided further help-seeking.

Most of the time I'll just sit in my room and cry or something. I don't talk to anyone about it. I mean I've tried (.) nothing against my mum but I've tried telling her before and she's said 'you've got no problems, you've got nothing to worry about, you're just being silly...I think that's why she thinks I haven't got any problems because well just I mean hormones and everything when you're a teenager (12: female, 18yrs).

Although these problems of legitimacy were particularly associated with parents, friends and peers, a smaller number of interviewees also feared their doctor would hold these beliefs and reject their requests for help. Two interviewees had previously encountered this. This was a reason for not approaching their doctor.

My mum took me [to the doctor's] when I was fourteen when it [depression] first started and he said it was just my age so after that that put me off completely ever going back about that ever again....so when my mum said go to the doctor's I thought no way on this earth am I ever going again even though it was like five years later, I thought no 'cos I thought he would just say oh its your age again and I just didn't want to waste all my time getting all my hopes up thinking yeah I'm gonna get help just for him to say 'nah' (3: female 20yrs).

(LB: You said you had seen your doctor [for physical complaint] and tried to convey how you were feeling) Yeah, I kept, when he asked me questions about physical things I would tell him the answer but then I'd try to tell a bit more...I would try and say, 'and it's also when I feel really stressed, and it's also when I haven't slept for a week'...and I was like, I'm trying to tell you something and then I did start crying. (LB: What do you think he would do if you actually said 'I think I'm suffering from depression'?) I think he would look at me and think you're just an 18-year-old female who's just finished A-level exams and I think you're just a little bit stressed (15: female, 18yrs).

Summary

A key theme of all interviewees' narratives was an attempt to negotiate the significance of their distress. Their illness behaviour centred around a struggle to define distress in relation to the polarised framework of 'normal' and 'real' distress. This was challenging because the framework was open to interpretation and there were several reasons why interviewees wished to avoid defining their distress as 'real'. In particular, they wished to avoid the stigma (felt and enacted), seriousness, treatments and 'irreversibility' they associated with 'real' distress. Their main response, therefore, was to adopt various strategies to normalise their distress. This allowed them to avoid both 'real' distress and help-seeking since help was considered inappropriate and unnecessary for 'normal' distress. The process was on-going. New, persisting or increasing symptoms challenged existing normalisations requiring the individual to renegotiate their position. Typically, they did this by further normalising. Interviewees' responses thus created a 'cycle of avoidance' where both having 'real' distress and help-seeking were avoided – help-seeking being the pivotal act that would 'make' distress 'real' by officially and publicly moving it across the threshold from 'normal' to 'real'. With each cycle, the threshold for 'real' distress was moved slightly further away meaning that despite increasing severity, interviewees could continue to occupy an intermediate position which allowed them to acknowledge their experience of distress while also classifying this as essentially 'normal' and so avoid help-seeking. Some interviewees explicitly described non-help-seeking as a strategy for avoiding 'real' distress. The next chapter considers interviewees' perceptions of help-sources and experiences of seeking help.

CHAPTER 7: PERCEPTIONS OF HELP SOURCES

Introduction

Chapter 6 examined key themes in interviewees' narratives concerning how and why definitions of mental distress and the need for help are negotiated, usually resulting in normalisation and coping rather than help-seeking. This chapter describes further reasons for non-help-seeking by exploring interviewees' perceptions of varying help options available to those who are mentally distressed and how these influenced their help-seeking behaviour. Data are presented relating to the help-sources discussed most frequently - the general practitioner, medicine taking, counselling, Samaritans and telephone helplines, and friends and family. Current and retrospective data are presented noting how perceptions were changed by experience. The term 'help-seeker' is used to refer to those who had received the type of help discussed while noting that pathways were not always voluntary.

The General Practitioner

All interviewees discussed using the general practitioner (GP) as a source of help for mental distress. Interviewees with long-term or past episodes of distress also described their previous beliefs and past encounters with GPs and how these had shaped their help-seeking choices.

Twelve interviewees (4 male: *i.d.* 14, 16, 19, 21; 8 female: *i.d.* 2, 3, 5, 9, 17, 18, 20, 23) had consulted their GP with mental health concerns on at least one occasion and at the time of interview, 6 were still receiving help (*i.d.* 3, 5, 14, 16, 18, 21). Their pathways to the GP were mainly delayed and brought about by significant events or crises such as a suicide attempt or the intervention or suggestion of lay contacts. Several interviewees had not therefore *sought* their GP's help but had become recipients of it (sometimes unwillingly). Two had chosen not to seek help for subsequent episodes of distress (*i.d.* 9 & 23) and others indicated a similar reluctance should they become distressed in the future. A few interviewees presented relatively straightforward or direct routes to their GP (*i.d.* 5, 14, 18). Of the remaining 11 interviewees who had not sought help from a GP, 2 were non-

cases presenting purely hypothetical data which nevertheless helped to illuminate common beliefs about the GP, 1 had attempted to communicate her distress during a physical health consultation (*i.d.* 15), and 1 was planning to consult (*i.d.* 11). The remainder ($n=7$) suggested that they would not.

Perceived appropriateness of consulting a GP

There was a widespread belief that GPs are not an appropriate source of help for mental distress and interviewees cited this as a primary reason for not seeking help. At the time of interview, 13 interviewees - especially non-help-seekers (8 out of 11) - held this view and it had been the perception of a further 4 'help-seeking' interviewees prior to their experiences of help. Notably none of these help-seekers had consulted of their own accord. Such views were absent amongst those whose help-seeking had been uncomplicated and direct (*i.d.* 5, 14, 18) thus reaffirming their importance to help-seeking behaviour. These help-seekers perceived a role for the medical management of distress.

Help-seeking from a GP was deemed inappropriate in two main interrelated ways which emerged from their dichotomisation of physical and mental aspects of health and 'real' and 'normal' distress.

Association of the GP with physical complaints only

More than half the interviewees associated GPs with the treatment of physical but not mental complaints. As a result, they were rejected as a possible help option, or at least, had not been thought of as one:

They're there for your bad ankle and cuts and bruises not for your mind games are they? (6: male 17yrs).

No, I don't think I would actually [consult a GP about depression]. I just associate my doctor with if I had a bad stomach or...yeah, I wouldn't go to my doctor no, no, not if I was depressed (22: female, 23yrs).

This belief was upheld even where no obvious alternative source presented itself:

I think the doctor's just, like you go to him if you've got a sore throat or something like that and he gives you medicine for it. If you're anxious, stressed or whatever, you er, (1) I don't really know where you go. (3: female, 20yrs).

If I've got a physical problem then I go to the doctor. If I've got a psychological problem then there's no-one really to go to (15: female, 18yrs).

Association of the GP with 'illness' only

GPs were also associated with the treatment of 'illness' only and as described above, mental distress was frequently categorised as non-illness. This was because it was normalised as passing stress or with alternative non-illness explanations, and although normalisation was a reason for not seeking help in general (Chapter 6) this particularly applied to help-seeking from a GP. GPs were perceived to provide only 'medical' help:

If I've given it a name like my job or family then there's almost sort of no point in going [to GP] 'cos like could a doctor help me with my job or could he help me with my family I mean I see that as something I'd have to sort out (1: male, 20yrs).

Mental distress did not accord with interviewees' physically orientated notions of 'illness', which defined illness according to whether physical symptoms or malfunctions were present. Mental symptoms and disturbances therefore were not recognised as episodes of illness and GPs, being seen as concerned exclusively with this concept of 'medical illness', were regarded as an inappropriate source of help for mental conditions:

I've always seen illnesses as like ill people and I don't think I'm ill 'cos like today I feel physically fine so as far as I'm concerned I'm not ill and that's why I think it's so hard for people to get like help with something like depression or stress or whatever... I see that I don't need to go to the doctors for that. I haven't got a leg falling off, I haven't got you know cuts up my arms or anything, it's just I happen to feel a bit down. (3: female, 20yrs).

These interviewees instead defined all mental distress, or 'normal' mental distress, as problems or 'feelings' or 'problems' and believed these required 'non-medical' methods of resolution, which were regarded as beyond the scope of a GP (see below), or had to be sorted out by the individual.

Perceptions about GPs' abilities and willingness to help

A series of negative evaluations of the GP and their ability to help those with mental distress followed from interviewees' restricted ideas about a GP's remit and the corresponding perceptions of inappropriateness. These reinforced the decision not to seek help from GPs.

GPs' knowledge, skills and training

A third of the interviewees argued that GPs lack sufficient knowledge and training in mental health to respond to mental disorder. In fact, some interviewees questioned whether GPs receive any mental health training at all. Following from their polarisation of physical and mental health, interviewees regarded GPs as physical specialists whose area of expertise is the 'body' as distinguished from the 'mind':

Doctors know how your body works 'cos it's physical but the mind is inside the head, no-one can see it. (6: male 17yrs).

They believed a GP would not know how to treat those with distress and so were unwilling to consult:

It's like learning history about medicine through the ages and how they used to tackle insane people and you know they cut bits of their brains out and things and people would generally end up like vegetables and I'm sure they [doctors] don't exactly know what the pills do to you... I'm not trying to undermine them or anything but they don't know what they're doing because they don't know how the brain works, I mean they don't know how to access it or change it ...I don't think personally that they can do much because it's all still guess work...I don't mind going there [to the doctor] for physical problems but I wouldn't go there for mental problems. (10: male, 16yrs).

Likewise, where mental distress was defined as 'problems' rather than illness the GP was perceived to be an unqualified and therefore limited source of help.

(LB: Do you think doctors actually know much about stress and depression and what to do about it?) They could probably just advise you. I suppose they would just refer you to somebody that did know because I don't know if that is their job to sit down with you and say oh well if you've got money problems go to the bank. (LB: But how about some of the feelings that go with those problems?) I just imagine the doctor would say 'oh here's some tablets' but nah, I don't think, doctors, I think they've probably got like a – they could just skim the water with it but not go in depth about it (22: female 23yrs).

Some interviewees implied that these may not be specific limitations of the GP but a general difficulty associated with mental problems because "no-one has studied the mind" (*i.d.* 6), but others demarcated mental health as the specialism of alternative help sources, usually counsellors or psychiatrists, whom they believed were trained and knowledgeable where the GP was not:

(LB: Who could help someone in that situation [depression]?) ...Someone professional who actually knows what they're talking about like a psychologist or a psychiatrist. Not your GP 'cos they're not trained to do it, they're just trained to look at you and give out medicines (16: male, 19yrs).

Incompatibility of the 'medical model' and evaluations of GP help

Most interviewees believed a 'traditional medical model' was the only operational model available to GPs. They associated this with particular methods of practice: observing and testing for disease and performing diagnosis; and types of treatment: administering 'direct cures' and 'fixing' parts of the body with 'fast turnaround' by means of medication and surgical procedures. Interviewees clearly identified this model with physical malfunction while perceiving it as incompatible with their beliefs about the nature of mental disorder.

Interviewees believed that mental distress was not observable and not amenable to medical treatments because they saw it as personal, internal and intrinsic to the self or one's life situation. 'Non-medical' and person centred interventions such as 'talking therapy', 'problem-solving' and 'caring' were regarded as more fitting (especially where they did not define mental distress as illness) but interviewees' narrow perceptions of GPs' approach and methods of 'treatment' meant that these were regarded as something that could not be provided by a GP. In fact, most interviewees believed talking about feelings and problems to be the main way of identifying and resolving mental distress but only four interviewees (three help-seekers and one non-help-seeker) recognised that the GP could fulfil a listening role. The use of medication for mental distress was particularly contested (below). The structure of primary care was seen to exacerbate these incompatibilities, with six interviewees regarding the time constraints placed on GPs as prohibiting the opportunity for talking, listening and caring. Seeking help from GPs was therefore seen as fruitless or of only limited value. These themes are illustrated further in table 7.1.

Table 7.1: The incompatibility of the methods and treatments associated with GPs because of the perceived nature of mental distress

Physical illness (medical model)	Mental distress	Incompatibility
Observable	Invisible, inaccessible	<i>Physical health is easier to cure than emotional health because you can go to a doctor's and he can say oh that's wrong, I can see it, or I can test for it whereas like emotional health you can't really do that (3: female 20yrs)</i>
External, curable, can be 'attacked' or mended	Internal, fixed, incurable, part of self	<i>I don't think it (depression) can be cured like other illnesses. It's not like something wrong with your body that needs to be mended or some virus that needs to be eradicated. Depression and stuff is you and it's hard to see how someone else can make you different. It seems sort of fixed. It's like you personally have fallen down a hole, your life, not just part of your body...(LB: So can it be cured or treated then, depression?) Dunno. I think it can to a point but there is also this feeling I get that its sort of not quite curable you know, like I've got it forever. I sometimes think its how I am and how I react to things or at least how I will be until my life changes and in that sense what can a doctor do except maybe be there as a safety net in case it gets really bad... (23: female, 24yrs)</i>
Amenable to 'treatments'	Treatments inappropriate	<i>(LB: So do you think a doctor couldn't really help you at the moment?) No they couldn't I don't think...I wouldn't want to take pills or have kind of people scanning my brain and things because unless I've got a brain tumour then I don't think there's much they [doctors] can do. (10: male, 16yrs)</i>
'Direct cures' and fast turnaround	Requires: <ul style="list-style-type: none"> Time Talking, listening, caring Problem-solving 	<p><i>(LB: Do you think they [GPs] are good people to go to for emotional or psychological problems?) Personally, no I don't think they are....They're sort of like 'oh you've got three minutes'. They just want your problem and an instant sort of cure for it...I don't think they'd be the right person to go to. (13: female, 20yrs).</i></p> <p><i>When it comes to mental health I don't think you can put too much emphasis on that sort of interaction side of the treatment, you know people actually there on your shoulder saying 'okay what's wrong, how do you feel, what's going on'. You know, people who you can talk to who will just stand there and just listen. (LB: so you don't really rate doctors as being able to do that?) No. (19: male, 23yrs)</i></p> <p><i>No, I won't go to my doctor. I just see a doctor as somebody that you would go to when you were ill. If you were ill, sick. But then if that's what doctors are for, talking to, I would but that's not what they're for. They're there to give tablets to people and you know. I can't imagine sitting down to my doctors saying 'oh my foot hurts and also I'm feeling a bit pissed off' (22: female, 23yrs)</i></p> <p><i>I think doctors are only there for medical problems so they wouldn't be able to help with your mind games...I don't think you'd be able to go for your ten thirty appointment with a doctor and they'd be able to sort your life out for you. (6: male, 17yrs)</i></p>

A small number of interviewees, particularly help-seekers, suggested ways in which the GP may be able to help - identifying what was wrong or explaining feelings (n=2), suggesting motivational exercises (n=1), alleviating symptoms (n=1), listening and offering support (n=4), and giving information and advice (n=2) - but in general, interviewees were sceptical, critical or confused:

(LB: Is it ever worth telling your doctor if you feel that way [suicidal]?) Um probably yeah but then they might just say that it's not a wise idea. I just don't think they would be that helpful, I don't know...I think they would just say well I think you should just go and see a counsellor if you're thinking of committing suicide, or just write a song or write a poem. (20: female 18yrs).

Nearly all interviewees identified medication and referral as two further types of 'help' that a GP could offer. Most saw medication as the only direct 'help' a GP could give and thought a prescription would be the likely outcome of a consultation. However, for reasons discussed in detail below, most interviewees regarded this as undesirable and a substitute for 'listening' and so this became a reason for *not* consulting a GP. Referral was a desired response and several saw the GP as the main way to access other help sources. Some consulted their GP, or suggested that they would, solely to achieve such referral.

That's the only reason I would have gone [to GP] is 'cos I know I can't go to a psychiatrist any other way, so that would be the only reason that I'd go (3: female, 20yrs).

I would go to a doctor if I wanted to seek help but I wouldn't go to the doctor for help with it. I'd expect to be referred. I'd expect him or her to sort of tell me I needed to go to see someone and refer me to someone else...its [the doctor] more of a middle man than someone who could solve the problem (1: male 20yrs).

One interviewee (*i.d.* 7) who had not been aware until the interview that a GP could refer, implied that knowledge of this might change his future help-seeking choices:

No, I wouldn't go [to GP]. It depends on how awful I felt, like suicidal, no, I still wouldn't. (LB: You wouldn't go if you were suicidal? Why not?) I wouldn't feel there's anything he could do. I feel there's other people that could help me. The only person I'd feel is like a psychiatrist or something and then there's the money issue. (LB: Did you know a GP could refer you to a psychiatrist?) No. (LB: would that change your mind about going?) Yeah well I don't really feel the need to go anyway but if I was [suicidal] yeah then now that I know that I would (7: male, 17yrs).

However, the GP's referral function did not guarantee help-seeking. Where interviewees saw alternative ways to access other sources the GP was bypassed.

In contrast, two help-seekers (*i.d.* 14 & 21) whose decisions to consult a GP had been relatively uncomplicated and who, unlike other interviewees, were positive about their treatment (below) differed with respect to these themes. One appeared to apply a 'medical model' approach to his depression. He attached less value to 'talking' and instead prioritised medication and therefore considered his GP's care satisfactory and necessary even though there was limited opportunity to talk.

(LB: Are doctors quite good people to go to then?) Well, I don't stay there for like ten minutes talking about myself, no. But I just tell them how I've been feeling like, the appointment could last about three minutes, then I just walk out the door really. (LB: So overall, do you think you get the sort of help you'd like or need?) Well as long as the doctor supplied the tablets I'm pretty sure I could help myself (21: male 18yrs).

The other, despite thinking of his depression as somewhat permanent, thought his GP played a useful role:

I think actually being depressed will always be a part of me and will always hold me back, to some extent. (LB: So it can't really be cured then?) No. It's not like er, I don't know, a mild cancer that can be, you know you can get the tumour or whatever, or inject some fluid and you're cured. Err, no you can't be cured. (LB: Can doctors actually help then?) Doctors can, yes, the anti-depressants, have helped, a lot. They can't cure the problem. They (.) the tablets can't cure, but they can help (14: male, 18yrs)

Beliefs about GPs' attitudes to mental distress

Twelve interviewees believed that GPs possess negative attitudes towards mental distress and those who consult with this. These concerns were raised by an equal number of non-help-seekers and help-seekers and were offered as a reason for delaying or not seeking help. Interviewees appeared to project their own beliefs onto GPs'. Several believed that GPs prioritise physical health problems, are disinterested or 'can't be bothered' with mental health due to 'a lack of physical attributes' (*i.d.* 15), that they would dismiss mental distress as 'not their area' (*i.d.* 3), not take mental problems seriously, or consider those consulting with mental problems to be 'time-wasters'. GPs were also thought to be unsympathetic of 'personal problems'.

Mum said go to the doctors and I said 'no they ain't gonna do nothing mum', I said they're just gonna you know say 'well if I had a pound for every person that come to say their boyfriend left 'em'. You know, I was expecting to hear that 'cos they're not the best on sympathy anyway, doctors (9: female, 23yrs).

Interviewees thought this would result in a range of dismissive responses from a GP, many of which related to the stigmas of 'real' and 'non-legitimate' distress (chapter 6).

They included being laughed at (n=2), judged as 'weird' or as a 'nutter' (n=6), being sent away without help (n=5), or being 'fobbed off' with medication (n=4). The fear of being dismissed deterred some interviewees from seeking help or made the exercise appear fruitless (Chapter 6). These themes were particularly evident in the account of interviewee *i.d.* 11 who was in the process of deciding whether or not to consult her GP:

(LB: You mentioned you were thinking of seeing your doctor?) Um, I'd say over the last month but its getting round to doing it...in a way thinking if I go up there are they gonna laugh at me and at what I'm gonna turn round and say and its like well I'm gonna be humiliated....'cos you know you feel as though you've got a problem there but at the end of the day you could go up there [to the GP], tell them how you're feeling and everything and they could just turn round, 'oh no we think you're fine' and send you away with a couple of leaflets or something...if I go up there and that's the case then I'm gonna feel oh right well they didn't want to really speak to me about it because I know that I feel that I have got a problem (11: female 22yrs).

Interviewees also suggested that GPs have preconceived ideas about who are likely to be 'genuine' sufferers of mental distress and several believed their GP would adopt a particularly dismissive stance towards young people who consulted with distress.

Experiences of GP help

Interviews also covered the experiences of the twelve interviewees who had sought help from their GP and whether these influenced their future help-seeking. One 'non-help-seeker' (*i.d.* 15) also evaluated her GP's help on the basis of her experience of consulting for a physical problem when she tried unsuccessfully to convey her distress.

GPs were evaluated positively for: referring the help-seeker to a useful source (n=6); prescribing useful medication (below) (n=4); being caring and supportive (n=2); and listening and showing understanding (n=3). Three interviewees found they were more able to talk to their GP than family or friends because they showed more understanding. One female interviewee remarked on how surprised she had been by the level of concern displayed by the GP. Others reported negative experiences. A small number thought they had been dismissed by their GP or told that they should 'get over' their problems (n=4), and that their GP did not offer sufficient help leaving them struggling to cope (n=2).

Some negative experiences reinforced beliefs about GPs lack of knowledge and the incompatibility of primary care with mental distress. On diagnosing mental disorder,

two interviewees described their GP as conveying a lack of certainty about how to respond to their problems.

It seemed almost like he [GP] didn't really know what to do about it [depression]. He was asking me what I wanted him to do and really I just wanted him to tell me what he was going to do you know. I just wanted someone to take control and help me (23: female, 24yrs).

Three female interviewees criticised their GP for placing an emphasis on testing for physical problems, which distracted them from identifying and responding to distress, one giving this as a reason why she would not return to her GP.

(LB: So you wouldn't consider going back to your doctor?) No, definitely not, no. I've sat in front of him before and sobbed because I was upset and he just did another blood test (15: female, 18yrs).

Past experiences – negative and positive – were therefore importance to future consulting:

(LB: Did being concerned that she [GP] might laugh at you put you off going at all?) I think considering how I was feeling it was worth going even with that risk and I'm glad she turned out the way she did 'cos if she hadn't I probably wouldn't have gone to another doctor (14: male 18yrs).

Prescription medicine taking

Ten interviewees had been prescribed medication for mental distress, but over half had delayed, avoided, or stopped taking these and another had been offered but refused them. Those prescribed were mainly anti-depressants but in a few cases also sleeping pills and anti-psychotic drugs.

Negative evaluations and affects on help-seeking

Most interviewees were highly critical about the use of medication for mental disorders and anxious to avoid this. In addition to general reasons such as lack of trust in medication and a dislike of its artificial nature, two thirds also provided specific reasons why they would not accept medication for mental distress. Medication did not accord with their understandings of the nature of mental distress and its causes and they believed several negative outcomes would result from usage (Table 7.2).

Table 7.2: Common objections and fears about taking medication for mental distress

Inappropriateness	
Mental distress not illness	<i>The thing that's really weird is the fact that my doctor actually prescribes me anti-depressants and I just can't get my head round that. I can't. It's just the fact that he's actually prescribing me something and I think to myself why do I need this? I'm not ill. (3: female, 20yrs)</i>
Cannot 'solve' the problem	<i>(LB: Would you ever consider taking [anti-depressants]?) Oh no, no. No. One, I'm not a tablets person and two, it doesn't deal with your problems does it?... (LB: What about physical things? Would you take tablets for that?) Oh god yeah. I mean I do like period pains or headaches, you know I would take a paracetamol or whatever but no, I don't think mentally. (LB: Why are they different?) Well, it takes away the pain doesn't it (LB: So what's wrong with taking away mental distress?) Its not really going to take the problem away though is it? (22: female, 23yrs)</i>
Objection to altering the brain, self or mind	<i>I wouldn't have taken them [if not forced to]. I don't believe in medication. (LB: How about taking medication like painkillers if you've got a broken arm or something?) I mean, yeah, yeah, I'd take that but to change your brain chemistry or something I don't believe in it. (16: male, 18yrs)</i>
Negative outcomes	
Addiction	<i>I wouldn't ever consider taking pills or anything because lots of people get addicted to them don't they and they can't cope without them then. (LB: What like anti-depressants do you mean?) Yeah and tranquillisers and stuff. You hear about loads of people getting hooked on tranquillisers (12: female 18yrs)</i>
Dependency/ reliance	<i>I just didn't want to start relying on anti-depressants to make myself feel better. I just wanted to overcome it myself...you might take the drugs, the anti-depressants and feel better and then not really attack the problem that's making you feel depressed in the first place....and then you just become reliant upon them. (4: male 21yrs)</i>
Side effects	<i>They [GPs] can give medication, which I suppose is helpful. I mean I would go again for that but only if I really couldn't see any other way than to take it because of my sort of fear of side effects.... In fact that probably is one of the main reasons why I don't go to my doctor now because I reckon they would suggest anti-depressants and I just don't think I could cope with trying them again right now (23: female, 24yrs)</i>

Interviewees could not reconcile the use of medicine with mental distress where they applied non-illness definitions. This made medicine taking appear nonsensical and inappropriate - particularly where distress and its causes were assimilated with 'personal problems'. In such circumstances, they opposed medicine use on the basis that it cannot 'solve the problem'. This was contrasted to physical illness where medication was accepted to attack the cause of illnesses or to provide relief while the illness was 'cured' in other ways. In fact, some interviewees suggested that medication could prolong the distress by preventing the user from addressing their problem. A smaller number of interviewees objected specifically to altering the brain or self with medication in any event, although they did not have the same concern about intervening with the body. Extensive 'talking therapy' and problem solving were perceived as more appropriate in the case of mental distress. Interviewees' objections to medication

therefore fitted entirely with their more general comments about the GP and incompatibility of the medical model.

A number of harmful effects were also perceived. More than half the interviewees believed that medicine taken for mental distress would become addictive resulting in a 'lifetime' on drugs or a need to be 'weaned off'. Interviewees were aware that patients may be on anti-depressants for months and contrasted this to a short course of treatment for a physical illness, or painkillers for a temporary injury. Also, on the basis of their belief that drugs cannot 'solve' the causes of mental distress, interviewees thought that medication would become a substitute for resolution, leading to dependence. A smaller group of interviewees were also concerned about adverse side effects including nausea, agitation, and becoming 'a cabbage' (*i.d.* 17) or a 'zombie' (*i.d.*19). It was evident from interviewees' accounts that these fears were mostly transmitted by the lay group, and in a small number of cases, from interviewees' own past experiences and observations of others. It was striking that a few interviewees drew parallels between anti-depressants and drugs such as heroin or speed.

*I couldn't go on it [Prozac] on principal because its basically relying on a little pill to make you feel happy or at least normal and it kind of makes me think of 'speed' or whatever. They take it to have a good time and then slowly it becomes they take it to feel normal, its like heroin, you know, it's just drugs.
(10: male, 16yrs)*

As evident from table 7.2, negative evaluations deterred interviewees from using medication and restricted their help-seeking choices. Although a small number did recognise that medication may have beneficial effects (below), mostly these were outweighed by their negative perceptions. Some actively avoided seeking help from their GP because they did not want to be prescribed medication.

I knew that they would probably prescribe anti-depressants and I'd heard some things about them so I didn't want to take them so I just left it...so I tried to cope on my own for quite a while. I would have rathered have coped on my own than be prescribed anything (18: female 18yrs)

I wouldn't mind going for help as long as they [doctors] could come up with a better solution than pills...If I knew I could go along and get something sorted in my head without having to be on Prozac then possibly I would go along now but I can't see that happening (9: female 23yrs).

These beliefs were also a main reason for non-compliance and breaking contact with GPs:

Loads were left in the packet and I didn't take them from the directions either...it was my friend saying 'oh don't take them 'cos my mother's had them and you can get addicted' and all that and I thought well I won't do it then...(LB: Didn't you think they'd help you at all?) Well they may have but I was worried about more the cons, the end of it, and I thought that oh I'm gonna want to go back on them or something or, you know, weaning a person off of them, I wasn't too happy about that idea (2: female, 19yrs).

They indicated that would only take medication as a last resort:

I can't see I'd go to the doctor again unless it was really where I just couldn't do anything and found I couldn't get by on my own. (LB: Why would you wait until it was that bad?) I wouldn't want to take anti-depressants again unless I really had to (23: female, 24yrs).

I would go on them (anti-depressants) because I've been quite worried sometimes about the thoughts I've been having and I'd prefer to go on anti-depressants than kill myself (15: female, 18yrs).

Lay members colluded with this avoidance and the search for alternatives:

I'm planning on taking them because I don't want to be like this forever but my mum and dad would rather that I didn't 'cos they've got me herbal things but they didn't really work 'cos they're worried I'll get hooked on them and side effects and things like that...my dad's heard lots of bad things about them so he didn't want me to take them and my mum took my dad's side and said you'd better try alternative things before you try things like that (18: female, 18yrs).

Positive accounts

Few interviewees spoke positively about the use of medication for mental distress. It was thought that medication could bring temporary relief, help one 'get along in life' and 'see light at the end of the tunnel' (i.d. 9) during a difficult phase. Six of the ten interviewees who had taken or been prescribed medication acknowledged its possible benefit, though some were trying to avoid taking this again for reasons detailed above. Four incorporated medicine taking as central to the management of their illness and essential to their recovery but only three were positive without reservation (i.d. 5, 14, 21). Compared to others, these interviewees did not report long episodes of non-help-seeking (i.d. 14 & 21) or for the episode for which they were being treated (i.d. 5) and had sought help willingly. They were also distinguished by the lack of reservation with which they applied illness definitions to their distress.

I'm hoping maybe I'll come off the tablets maybe early next year. I'm not in a rush to come off them, because if I just stop taking them like that I'd go straight downhill (14: male, 18yrs).

Maybe it [depression] will go without medicine but I'm not entirely sure. I think it's going to be there for a long time and the only thing that's gonna stop it is the medicine or myself. I mean I've had people saying to me you're the only person who could take yourself out of it. But I don't think you can just take yourself out out of being depressed...I don't think it's like that, as far as I know (21: male, 18yrs).

Those who were positive about medicine taking formed the same group as those who were positive in their evaluations of the GP as a source of help. An individual's orientation to medicine taking therefore appeared central to the likelihood of them considering the GP as a useful source to consult for mental disorder, though it is not clear whether they held these views prior to seeking help.

Meanings of taking medicines for mental distress

Interviewees and their wider social groups attached many of the negative meanings associated with help-seeking (Chapter 6) specifically to the use of anti-depressants and other medicines for mental problems. Several said their condition would have to become overwhelming before they took medication. Interviewees attached a high degree of seriousness to medicine-taking.

I've got a friend at the moment whose been going through a bit of a bad patch and I've just realised that he's been put on anti-depressants and I think that's just horrible, its not really the best way to go about things...my personal feeling was a lot of shock when he told me and I was just going 'oh my god, why are you on such a serious thing'...to me it seems a really sort of very serious step to take (13: female, 20yrs).

Many understood being prescribed medication as a sign of 'real' distress (Chapter 6) and two described prozac as 'the drug for manic depressives'. This affected their willingness to seek medical help and accept medication.

I really didn't want to get involved in that [taking medication]. I suppose it makes it feel really real if you're having to see a doctor to get prescribed drugs just because you're feeling emotionally ill, that would really make it hit home. I really didn't want to get to that stage where I was having to take drugs just because I was feeling emotionally ill to make myself feel better (4: male, 21yrs).

Taking medicine for mental distress was also associated with weakness and signalled an inability to 'cope'. This provoked shame and again indicated 'real' distress, thus motivating interviewees to try to cope without medication.

Once anyone knows you're on anti-depressants you're classed as weak or you can't cope with life, what are you going to do, go and kill yourself now?...As far as like going back on 'em [Prozac] I probably would keep it quiet...it's like

'oh god I'm on these, proof that I'm weak...I feel I'm weak and then obviously they [lay people] think I'm weak and this is why I'm chuffed that I'm managing at the moment [without taking Prozac] (9: female, 23yrs).

As taking medication defined the user as 'mentally ill', it was also linked strongly with stigma (above). This was a reason for avoidance, non-help-seeking and non-compliance.

(LB: Was it your choice to come off the Prozac?) Yeah, I don't know what it was but there's always such a stigma to it. Its like my friend. Her mum works in a chemist so she said 'mum saw you in the chemist' – and I was getting prozac – 'oh god you don't want to take them', made me feel like I'm a right nutter...so I think sometimes that's why a lot of people might not go to get help (9: female, 23yrs).

Some interviewees' accounts suggested that there is a perceived incongruity between being young and taking medication for mental problems shared by some interviewees and the wider lay group due to beliefs that young people do not suffer 'real' distress. This added to ideas about weakness and stigma.

I think I'm really probably too young to take anti-depressants which the doctor who prescribed them did say that she thinks I'm quite young to take them. That's what my dad said as well, he said 'oh my 18 year old girl is on anti-depressants' you know 'its not right'. (LB: Do you think it's associated with older people then?) Yeah, 'cos I think a lot of people see it as what have young people go to worry about. They've got their youth and going out to clubs and things. They've got nothing to worry about (18: female, 18yrs).

Counselling

Eighteen interviewees discussed counselling as a help option and several contrasted this with seeking help from a GP. Seven interviewees (5 female, 2 male) had received counselling, one of whom was still attending sessions. Only one (*i.d.* 23) had actively sought this (though she had done so secretly) – the others were encouraged or coerced to attend by parents, a GP or teacher. Five terminated the relationship prematurely finding it to be unhelpful. A further interviewee (*i.d.* 18) was awaiting an appointment at the time of interview following a GP referral and a further two expressed a current desire for counselling (*i.d.* 11, 22).

Perceptions of counselling of a source of help

Interviewees presented ambivalent accounts of counselling. On a hypothetical level, all except for one male non-help-seeker (*i.d.* 7) assigned a high degree of appropriateness to

counsellors as a potential help source for those feeling mentally distressed or suicidal. In fact, nearly half considered counselling to be the main source of help in such instances and four non-help-seekers said that counselling would be their first help-seeking choice. This was in striking contrast to their perceptions of the GP and medicine-taking as sources of help and interviewees drew frequent comparison. The reasons for their positive evaluations of counselling mirrored their criticisms of GPs (Table 7.3).

While interviewees associated GPs and medicines with physical illness, counsellors were associated with 'problems' and 'the mind' and half explicitly described them as 'professionals' and 'specialists' in this area with specific skills and training exceeding that of the GP and akin to psychiatrists or psychologists. Conceptualising mental distress as 'problems' that needed to be resolved rather than illness that could be treated, some interviewees presented this as the reason why they had sought or would seek a counsellor's help rather than a GP's. Interviewees also perceived counsellors to provide the type of help that accorded more than 'medical' responses with their understandings of mental distress and how it may be 'cured' and which they thought were not available from GPs (above). Most saw counsellors as: facilitating in-depth talking and expression of feelings, which was regarded by most as fundamental to resolving problems and working through emotions; and offering advice and providing 'answers' to problems. A smaller group of interviewees thought that the counsellor's role extended to identifying the underlying causes of mental distress and resolving these, acting as a confidant, and giving understanding and support.

The appropriateness of seeing a counsellor rather than a GP was reinforced by the belief that a GP would refer help-seekers to a counsellor given their own inability or lack of time to deal with emotional matters.

They [doctors] might think that whoever's going to them for that reason is a bit..well, maybe they're not considering that there might be someone ill out there and they are just going to the doctor to seek advice about an emotional problem or to talk to the doctor. So then, that's why they [the doctor] would say go and see a counsellor (20: female, 18yrs).

Table 7.3: Positive evaluations of counsellors as a source of help

Remit and specialism:	
<ul style="list-style-type: none">Professionals/ specialists in mental distress/ ‘the mind’.	<i>A doctor probably wouldn’t be any help. They might be able to point me in the direction of help. Either psychiatrist or counsellor or any other specialist (6: male, 17yrs)</i>
<ul style="list-style-type: none">Training and knowledge	<i>If you go to a specialist sort of person like a counsellor then they will have more time and more skills to deal with your problems (13: female, 20yrs)</i>
<ul style="list-style-type: none">Specialise in ‘problems’ rather than ‘illness’	<i>Maybe I should go to someone like a counsellor..(LB: Do you think you would actually go?) Yeah, definitely, definitely (LB: Because you said about your doctor that you’d think of lots of reasons to put it off. I wondered if you’d do the same) No because I’d know that the counsellor was for that where the doctor is for your sickness, and the counsellor would be to deal with your problems. (22: female, 23yrs)</i>
Operational model and ‘type of help offered:	
<ul style="list-style-type: none">In-depth talking, listening and problem solving	<i>If I was feeling depressed I’d go to my doctor and they’d say I can’t help you but this lady can, give me a contact number or set up an interview for me and then I’d like to think I would go there, say everything I’m feeling, all the problems I’m having and then hope the counsellor can talk back to me and help me out (6: male 17yrs)</i>
<ul style="list-style-type: none">Discovering and resolving underlying causes	<i>Depression isn’t something that you can just cure over six months kind of thing, its something that needs to be talked through because it goes a lot deeper than sort of taking some drugs just to calm you down and as I said before it could go back to childhood, to your family and to your general personality so counselling would be more the way forward I would say (13: female, 20yrs)</i> <i>People can be talked out of it [suicide] but momentarily, unless you’ve got proper help they probably can’t talk them out of it properly, permanently. (LB: Did you say proper help?) Yeah, I mean if somebody sat down with them and talked to them and tried to find out the causes of the problems and help them sort them out then they probably won’t get the right help otherwise. (LB: Who could do that?) I don’t know, er counsellors, people like that that are experienced. (10: male 16yrs)</i>
<ul style="list-style-type: none">Supporting and understanding	<i>I thought it might be nice to have someone to talk to. I sort of saw it as if your friends and family wouldn’t understand then perhaps this person [the counsellor] would (1: male, 20yrs)</i>

For two female interviewees, their preference for counselling related to the meanings associated with help-seeking (Chapter 6) and their perception that counselling was ‘less serious’, ‘off the record’ and did not involve ‘treatment’.

(LB: What made you choose a counsellor rather than going back to the doctor?) I suppose it seemed like an easier option in a way...it just doesn’t seem as official or serious as going to a doctor. I knew I could go and talk without getting involved in medicine and stuff which I don’t really want to do so it was just a different approach (23: female, 24yrs).

Ambivalent evaluations of the 'actual' benefits of counselling

When considering the actual possibility of seeking help from a counsellor some interviewees became sceptical and their accounts became inconsistent. Negative evaluations emerged which were cited as reasons for not seeking help. This was particularly apparent where non-help-seekers who had considered seeking counselling accounted for their eventual decision not to do so, and amongst help-seekers with negative personal experiences of counselling. Males appeared to be more sceptical than females.

Almost half the interviewees believed that help provided by a counsellor might prove ineffectual. This was because they began to question counsellors' true expertise and ability to solve problems:

Counsellors don't really know what they're talking about either..it's not worth going to the counsellor but people do thinking it does help...doctors I think are different to counsellors 'cos doctors know what they need to know and know everything that is about the body, counsellors although they know more than anyone else about the psychological mind games and everything else, they don't know everything, they don't know how it works, what sets off feelings, how to shut off feelings or anything else so they can only talk to a patient the best they can (6: male, 17yrs).

They also questioned the real efficacy of talking and thought that any emotional relief would be short-lived:

I don't think I would like to go [to counselling]...I'm sceptical as to whether or not talking about a problem (2) I imagine a lot of talking and a lot of discussing problems but I'd want something physically there to help me out...talking to someone else wouldn't have helped me, well I don't think it would have helped me out. I wanted an answer to my problems, I wanted a way out...I think it would help while I was in the room to talk about how I felt and it would help to have someone to listen and to understand how I was feeling but then I imagine just coming away from that person and the feelings all still being there (1: male 20yrs).

Three female non-help-seeking interviewees however, maintained their belief in the usefulness of counselling, perceiving it to be their main option for recovery. One respondent was waiting for an appointment at the time of interview and the remaining two stated they were planning to seek counselling shortly.

The sooner I go and see one [a counsellor] the better which is why I've got to go up to the doctor's this week sometime, even if its classed as an emergency appointment 'cos my life is non-existent at the moment. I need to pick myself up but I do feel going to see a counsellor would be a hell of a lot better and it will get me back up there I know it will (11: female, 22yrs).

Negative meanings of counselling

The themes of stigma and weakness (Chapter 6) were also linked specifically with counselling and interviewees revealed how this could compromise help-seeking. The desire to avoid such stigma motivated avoidance of counselling or the attempt to conceal attendance. Half the interviewees believed that stigmatising labels and responses associated with 'mental illness' are applied to those who are seen to have a need for counselling and currently or previously shared this view.

If you're going to counselling sessions that's probably because you've got a problem and there's something wrong with you so you're probably a bit screwy or something to need counselling (10: male, 16yrs).

I think a lot of it is people might not want to tell their friends that they're going to see a counsellor because they might think they're a bit doolaalee or something (22: female 23 yrs).

Counselling also provoked feelings of weakness and embarrassment.

I went to see a counsellor and I didn't tell anyone about that. I did tell my boyfriend eventually but I did find that hard and felt a bit silly at the time...I think I was a bit embarrassed that I'd felt I needed to. Like it was weak of me (23: female, 24yrs).

It was notable that interviewees discussed the stigma associated with counselling within the context of friends and peers rather than their families or wider society and several accounts suggest these difficulties applied particularly to males and are amplified where counselling occurs within the context of school or college services.

(LB: How did you feel about seeing a counsellor?) At first, because it was at school and like in the main hall and just in this door, at first I thought 'oh I bet people' (1) like I felt a bit nervous about standing outside when I had to wait 'cos I thought people might think I was a freak or something by going there...because I mean if it wasn't at school then it would have been somewhere else so then I wouldn't have been waiting outside the hall where people who knew me could see me (20: female 18yrs).

They set up a counselling service at my college and everyone took the piss out of it....and everyone kind of alienated people, like there was a friend of mine....and she went to see a counsellor and everyone just took the piss out of her because they thought that she was a nut (15: female, 18yrs).

Stigma was linked to a number of undesirable social responses from peers. These included avoidance, excessive discussion and speculation about the individual and the nature of their 'personal' problems, social ridicule, judgement of the person and their need for help, a general lack of understanding and sympathy:

Some people might feel embarrassed if their friends find out 'oh he's just been to see a counsellor 'cos he can't handle he's got no money and he's just lost his dad, he can't handle it. Some people might take the mick or be talking about that person...'oh when's he next going to see his counsellor, he's weak, can't he handle it? I can handle all the stress I'm having, why can't he?' (6: male, 17yrs).

Personal experiences of counselling

Of the seven interviewees who had experience of counselling, two were positive about their experience believing that counselling was helpful in resolving issues and feelings and allowing them to talk. The remainder were critical and five had terminated the relationship prematurely. These interviewees reported no improvement in their situation or feelings and were critical that they had not received the answers or solutions they had expected to. One interviewee (*i.d.* 5) assimilated counselling to 'chatting' as she might with a friend. Interviewees also made practical criticisms about the service they had received - for instance, that it was provided at the wrong time and was too infrequent - and criticisms of the specific counsellor they had seen, for instance that they were judgemental, disinterested, uncaring, or too old and therefore hard to relate to.

Samaritans and telephone helplines

Twenty interviewees discussed the Samaritans and other telephone helplines ('Childline' and 'Saneline') as a potential help-seeking option in times of mental distress, but only two (*i.d.* 2 & 21) had actually called a helpline - in both cases, the Samaritans - and a further three reported considering doing so (*i.d.* 16, 17, 23). Most interviewees recognised that such services could provide some help though thirteen interviewees, including the two who had previously called the Samaritans, definitely ruled this out as a future help-seeking option for themselves. The others were undecided. There did not appear to be any gender differences in interviewees' views about the Samaritans or other helplines.

A female respondent (*i.d.* 2) called the Samaritans on the suggestion of her mother on a day she felt particularly distressed and prior to receiving help from her doctor. She had preferred to do this than seek help elsewhere because of the anonymity afforded through the telephone and the fact this would allow her to escape other's judgement. A male respondent (*i.d.* 21) called when he was feeling suicidal. He had also sought help

from his GP for feelings of depression. Interviewee 2 did not consider the service to have met her needs because it provided no continuity of care and interviewee 21's call had not been helpful because the Samaritan had hung up. He offered three suggestions for this: that he had 'talked too much', that it was late, and that his call might have been mistaken for a prank. Nevertheless, he maintained that the Samaritans could be a useful source of help.

'Need' associated with use of the Samaritans

Most interviewees saw the Samaritans as a help source for those with extreme distress only and believed that they should only be contacted in moments of severe or suicidal crisis or when encountering major problems such as domestic violence and drug addiction. This was a reason for interviewees not seeking help since they thought they were not 'bad enough' to justify this, but still only 3 interviewees suggested they might seek help from the Samaritans should they reach such a situation of desperation.

I've been very very close [to calling the Samaritans] but I've never had the guts to do it...I felt that my problems weren't bad enough for someone that might need it, that there could be someone out there that could be really that close to the edge like you know to do something....I always felt at the time that my problems are nothing up to what some people are going through...I always felt I don't want to clog up their telephone lines for someone that really does need it. (17: female 23yrs).

Some associated users of the Samaritans with the stigmatising labels applied to mental illness.

(LB: Did you think of anywhere like the Samaritans?) I thought the Samaritans was only for freaks like people who were like really on death's door would ring up and wife battered people, things like that...and I didn't want to be a freak (3: female, 20yrs).

However, one respondent (i.d. 8) who advocated GP help-seeking held an opposing view, perceiving helplines including the Samaritans as dealing with trivial problems and 'teenage angst' and so did not regard them as a suitable source of help for those with 'real' mental distress.

(LB: What are your opinions of telephone helplines?) That's very teenage type of thing...It could be like that you know, just phoning helplines, 'Oh I've got this problem and its with my girlfriend', not really serious. I think it could cause pranks at the end of the day as well (8: male, 17yrs).

Perceived limitations of helpline 'help'

Half the interviewees criticised particular aspects of the nature of helplines and gave these as reasons why they would not use them. They objected to the remoteness of a help source contacted anonymously by telephone and only two were aware that it was possible also to visit the Samaritans. Remoteness was seen to translate to a lack of relationship with the help source and impersonal help provided by someone who does not know their client. They thought this would compromise the type of help that could be offered and said they would rather discuss their problems face-to-face. Only four interviewees found the anonymity of a helpline desirable to maintain privacy and avoid embarrassment.

I don't think anyone could reassure you or know what you're going on about until they've made that bond with you..I don't think you'll have that rapport with some faceless person over the phone who you know every time when you phone up isn't going to be there (19: male, 23 yrs).

While acknowledging that the Samaritans could offer support, most considered the actual 'help' offered to be limited because they viewed Samaritans as passive listeners who offer momentary emotional support but will not advise or in any way actually assist with or solve the callers problem.

You can't help wondering what the point of ringing the Samaritans would be. You know, you put the phone down and that's it. Nothing's changed, there's no-one even to say to you in a few days are you okay, how are you feeling now because when it comes to it you haven't really even fulfilled the cliché of a problem shared is a problem halved because you haven't really shared it with anyone....you've just shared it with a voice on the phone who'll put the phone down, fill in the paperwork and file it and they're not going to take any of the burden or responsibility of your problems. And I don't mean that as any criticism of them, it's just the way the service works. It's a cathartic release sort of thing but its not really help (23: female, 24yrs).

There were mixed views on the Samaritans' expertise. Two interviewees described them as experienced and as 'proper help' (i.d. 10) where doctors were not, but others placed talking to the Samaritans on the same level as talking to friends and family.

The lay group

Interviews also explored interviewees' perceptions and experiences of using their lay group as an informal source of help in times of mental distress. This included mainly friends, family and partners but also teachers and work colleagues.

The data obtained are complicated by the longitudinal nature of some interviewees' accounts and their differing illness behaviours at varying phases of their trajectory or with the re-emergence of distress. Also, some interviewees were prepared to seek help from friends but not family or vice versa. Informal lay sources became involved in the illness trajectories of interviewees by varying pathways. Some interviewees had intentionally sought their help, but in other cases, the lay group had confronted the individual or intervened in illness behaviour. Such complexities present difficulties for classifying individuals as help-seekers and non-help-seekers. This difficulty is compounded by the varying nature and context of lay group 'help-seeking' across individuals, which ranged from casual conversation about 'feeling stressed' usually with little consequence, through in-depth confiding of problems and feelings, to seeking advice about symptoms and whether to seek help. In short, 'help-seeking' from friends or family cannot be as easily defined as a GP or counsellor's appointment or a phone call to the Samaritans. This complexity is summarised in Table 7.4 which shows males and female interviewees separately as, unlike help-seeking from the other sources discussed, there were clear gender differences in lay help-seeking in terms of both actual help-seeking behaviour and the views expressed.

Only three male interviewees described lay group help-seeking (*i.d.* 4, 14, 19), one was older and married and confided in his wife, but did not seek help for his main episode which occurred before his marriage (*i.d.* 19), and another did not seek lay help until confronted by parents (*i.d.* 4). In contrast, most females had sought lay group help. Females were also more likely to confide in partners/boyfriends and to use additional lay sources such as teachers or colleagues.

Table 7.4: Interviewees use of the lay group as a source of help

Males		Females	
I.D.	Description of help-seeking	I.D.	Description of help-seeking
1	Did not seek lay help. Thought friends would be dismissive. Assigned parents implicit role in motivating him and therefore preventing him from becoming very depressed.	2	Sought help from friends. Asked for advice about her symptoms and what she should do about these.
4	Did not seek lay group help. Was eventually confronted by his parents. He then confided in them about his feelings of depression.	3	Spoke to mother and a friend about feelings of depression who were initially dismissive but after suicide attempts they alerted her doctor and encouraged her to consult.
6	Hypothetical data (non-case). Said that he would not talk to friends or family about distress.	5	Previously did not seek help from the lay group but described more recent help-seeking from husband, family and family.
7	Has not sought help from friends and family other than to comment casually about 'feeling miserable'.	9	Did not seek lay group help until confronted by her mother. Has confided in family and friends but does not do so now as she says they are dismissive and not understanding.
8	Hypothetical data (non-case). Said he would seek help from family but not friends.	11	Has spoken to friends and colleagues and asked for advice about whether she should go to her doctor.
10	Has not sought lay help. Suggested that he would speak to friends or family before seeking professional help.	12	Has previously spoken to friends and attempted to talk to parents but found their responses dismissive so no longer confides.
14	Sought help from parents and a female friend. Emphasised the importance of lay group help-seeking in addition to formal help-seeking.	13	Sought help from her boyfriend but not parents.
16	Did not seek lay help. Was confronted by parents who took him to GP. Does not confide in parents and has not spoken to friends at all.	15	Spoke to a teacher and some friends but did not in either case disclose the actual extent of her distress.
19	Originally sought no lay help. Was confronted by employer and referred to formal help-services. Has since married and now talks to his wife about distress.	17	Did not seek lay group help for past episode. Now talks to partner and friends about problems and when 'stressed'.
21	Did not seek lay help. Was originally confronted about his distress by his girlfriend at the time and her mother.	18	Sought help from parents for panic but not depression. Also confides in her boyfriend but will not talk to friends about distress.
		20	Sought help from a teacher and friends but did not talk to parents.
		22	Has not sought help from family or friends though says her feelings of depression did 'come up in conversation' once when talking to a friend.
		23	Did not seek lay help, even after attending her GP, but was confronted by a colleague which provoked the consultation. More recently has confided in her boyfriend.
Total seeking and receiving lay help: Sought=2/10 Received=4/10		Total seeking and receiving lay help: Sought=10/13 Received=11/13	

Appropriateness and availability of lay help

All female interviewees and most males acknowledged that friends and family could be an appropriate source to consult when feeling mentally distressed. Typically, the lay group was viewed as a first option that should be explored prior to formal help-seeking. The lay group were also clearly delineated as the help source for 'normal distress' while there was recognition that 'real' distress should be referred to a professional source (Chapter 6).

(LB: How important is it for people to go for help?) Well I think they should try and sort it out with talking with their family or with a friend first. And then if that doesn't help and they don't get a conclusion from it, then they should go a step further which is to see a counsellor or see their doctor (20: female, 20yrs).

For some the lay group was perceived as the *only* option since the doctor had been discounted, but three interviewees (two male, one female) stated a preference for formal professional help sources rather than friends or family. Over half the interviewees thought their lay group was an available and accessible source of help for mental distress or personal problems but only three of these were male. Friends were more often seen as a source of help than family. Perceptions of appropriateness and availability did not guarantee help-seeking as fewer had actually sought help when distressed.

Female interviewees provided descriptions of confiding and health conversations occurring within their lay networks as normal and well-established behaviour. They gave examples of situations where they and their friends had confided in each other ranging from casual confiding to in-depth discussion of serious life events.

I'm like your regular agony aunt with all my friends so whenever they have arguments with their boyfriends or anybody or their mum or dad or something they always phone me up. It's quite funny actually sometimes because like last week my friend rang me up and she's had an argument with her boyfriend and she ended up writing down everything I said (12: female, 18yrs).

I can still go through, as I put them, low patches...[respondent describes recent life event] I went really down, really upset, lots of tears and I ran out of the house and went to see the friend I was telling you about and I told her everything...and then I went back after a while, about two or three hours talking to her and having a cry and all that kind of thing (17: female, 23yrs).

Some specifically mentioned confiding about mental distress and its treatment.

I said [to distressed friend] 'oh, if it's really that bad', I said, because I was worried about her basically, and I said 'come over my house' and she said, 'oh, no. I'm not going to do anything stupid [suicide]' and I said 'how do you know?' and she said 'well, have you?' and I went 'yeah, I thought about it' (17: female, 23yrs).

However, such descriptions were absent from most males' accounts.

If you've got friends around you you can talk to or someone who could help you then yeah I think it's a good idea but I'm not sure where I would go if I needed that sort of help (1: male, 21yrs).

In striking contrast they suggested there is a general tendency amongst young people, *not* to confide in family or friends and portrayed non-help-seeking as 'the norm'.

You could talk to friends and family to help you overcome the problems but most suicide cases, no-one goes for help do they? They just bottles it all up inside....(LB: Do people talk to each other much about things like depression, do you think?) I don't think so, there's probably a few people out there who are really close to their family and friends that might be able to but I don't think there's many who do talk about it (6: male, 17yrs).

(LB: What can you do about that [feeling depressed]?) It is the correct answer to go and see somebody about it but you can't really 'cos, well how many people talk to a friend? You're not gonna do that (7: male, 17yrs).

Where it occurred, male confiding was generally limited:

(LB: Do you ever talk to friends about feeling depressed?) Not seriously, kind of like 'oh, I'm just really miserable at the moment and stuff like that...they were just like, 'oh, don't worry about it man, you'll find someone else' or something, or you'll get better, or you'll get this or something, basically just what anyone would have said in that situation (7: male, 17yrs).

Three male interviewees presented differing accounts as they did believe lay support to be available but in each of these cases they assigned this role to a female (and one also to his parents) and in keeping with other male interviewees, did not see their male friends as an accessible help source but instead as social contacts and drinking companions.

I've got a very wide range of friends, I've got my football friends, my rugby friends, my friends that I can go out and have a laugh with, my friends I can go out and have a drink with and my friend I can talk to if I need to talk about something like that [stress/problems]...if I needed to I'd talk to her (10: male, 16years).

This distinction was confirmed by another respondent who thought he would only be able to confide in a female.

(LB: But would you rather have someone to talk to than rely on yourself?) If I knew that I could trust them, yeah. I mean it would have to be a female that I

trusted because I just basically can't get in to a subject about my feelings with a male. It would have to be a female to even come close to that...I mean when it comes to drinking I'll have a good time, it's my male friends but when its just having a friendly chat or something its always the women. (LB: Do you think your male friends would understand?) No 'cos they're all like, they just want to go out drinking and having a good time (21: male, 18yrs).

Availability was an explanation for seeking lay help first or instead of other options. The presence of friends and family in the context of distress gave them an immediacy that could also promote understanding.

I was talking to them [friends] about what was going on...(LB: What made you talk to them?) Because they're around me, they're there, they go to college...so I mainly got my friends involved a lot more than medical people...it was just the way it worked (2: female, 19yrs).

However, in the actual context of their specific episodes of distress, nearly half the interviewees (again mostly males) perceived a general lack of lay sources or opportunity to talk with friends or family (table 7.5) and therefore did not, though in fact the lay group had intervened in the illness trajectories of many of these interviewees. The reasons offered for this lack of availability were: the absence of a confiding relationship with parents attributed to 'being young', upbringing, and family breakdown; friendships that had been disrupted due to transitions of young adulthood such as moving to university, or unstable relationships; and a sense that mental distress was taboo or simply not a topic of conversation amongst peers/ family. Some longitudinal accounts (*i.d.* 17, 19, 23) demonstrated that availability had changed over time, becoming more attainable with maturity and finding a partner.

Additionally, it was evident from some interviewees' accounts (n=8) – particularly those who had sought help from friends and family on some occasions but not others – that perceptions of the availability of lay help or appropriateness of seeking this were situational, varying according to their 'problem' and the circumstances surrounding this. It was thought (and sometimes proven) that lay help was unavailable or should not be sought where:

- Distress related to certain personal problems of life events that were considered 'unmentionable', the source of family tension, or the outcome of 'bad behaviour'
- Friends of family were the focus of problems or emotions

- Distress related to specific matters that impacted upon the whole lay group such as divorce or family illness, or occurred within this context
- The individual felt responsible for family distress
- They thought that their lay sources had their own problems/ stresses.

In such circumstances, it was thought that asking for help and revealing distress was unjustified, could add to other's distress/ burden, or make the situation worse. These were often reasons for seeking help from friends rather than family, but the perceived need to conceal distress from family could also restrict the opportunity to seek help from formal sources (*i.d.* 12, 13, 15, 23) – especially a 'family doctor'.

Table 7.5: Reasons why the lay group may be unavailable sources of help

Lack of relationship with family/ Unstable families	<i>I tried slashing my wrists but I never did it deep enough. It was just feeling so low that like you don't think there's a life for you and a future....(LB: Do you think anyone can help people that are feeling like that?) I wouldn't know. I suppose if you could just show someone in that position the value of life and that you will be happier and you're going to meet new people.. (LB: Can you think of anyone you could contact?) Well, a close family, friend. (LB: Would you do that?) Well if I was close to someone, yeah I would, but all through my life I've never really been close to anybody... I've learnt to just be my own friend. I'm like my own father figure because my dad wasn't very nice you know (21: male, 18yrs).</i>
Disrupted friendships	<i>(LB: Would you talk to friends [about mental distress]?) To be honest I don't have any friends – not any more – 'cos I've just left school so all the school friends I don't have. I have got college friends but I only see like one or two of them outside college hours so really I've only got my girlfriend and like one best mate I ever see, speak to or be with anymore but both of them I've only known for the last six months so I don't have a close relationship with them and I wouldn't talk about health problems or relationship problems with them (6: male, 17yrs).</i>
Mental distress not a 'topic of conversation'	<i>It's [mental distress] one of those things that when your friends are suffering from you don't really hear about it...like I couldn't say how many of my friends have been affected by it...Its not something you tend to talk about. I certainly wouldn't be willing to tell all my friends that I was feeling depressed and so a lot of my friends might not realise when I've been depressed that I was, so I can see it could be the same for me with them when they've been feeling down or depressed (4: male, 21yrs).</i>
'Unmentionable problems'	<i>My parents didn't want to talk about it [respondent's abortion] and 'cos my brother and me we do get on pretty well and I can talk to him about quite a few things but I've tried telling him about it and he's just said 'I don't want to know'...I did actually try and talk about it to my mum a week ago and as soon as I started talking about it she just walked out of the room and started talking about something else and I wouldn't even try and talk about it with my dad (12: female, 18yrs).</i>
Problem/ distress affects the whole family	<i>There was a lot going on at the time [of parents' divorce]. I mean my parents had their own stresses and I didn't want to add to that. Things were bad enough and I couldn't see it would improve my situation if I talked about it [distress and DSH]. It would have made it worse because it would have made things with them [parents] worse (13: female, 20yrs).</i>

Evaluations of lay group help

In contrast to accounts of the GP, most interviewees described a number of ways in which the lay group, in principle, may help a distressed individual. However, evaluations of the lay group were mixed and many interviewees also held negative perceptions and suggested reasons why they may not seek their help (Table 7.6).

Table 7.6: Competing evaluations of lay group help

Positive	Negative
Personal relationship <ul style="list-style-type: none">• Approachable• Trust and rapport• Individualised approach• Caring and genuine	Too close to offer help <ul style="list-style-type: none">• Embarrassment• Fear of disappointing expectations and ‘letting parents down’• Fear of imposing on or disrupting relationships
Support from someone with similar experiences	
Listening role <ul style="list-style-type: none">• Share feelings/ problems• Express emotions	Unwilling to listen <ul style="list-style-type: none">• Discomfort at emotional expression
Can assist with problem-solving <ul style="list-style-type: none">• Practical help• Advice	Cannot solve problems <ul style="list-style-type: none">• Do not know what to do or say
Support-giving and understanding <ul style="list-style-type: none">• Emotional support• Reassurance• Comfort• Encouragement/motivation	Lack understanding and empathy <ul style="list-style-type: none">• Dismissive response• Stigma• Withdrawal of friends and family
Social function <ul style="list-style-type: none">• Company• Distraction from distress	Recommend ‘bad’ coping techniques <ul style="list-style-type: none">• Drinking/ smoking• Drugs

Positive and negative accounts were sometimes in direct competition and often influenced by interviewees’ own past experiences of lay group help. In other cases, the disjunction between positive and negative evaluations emerged as interviewees moved from hypothetical discussion to consider lay help in the context of their own episodes and to explain why this had or had not been sought. Male accounts tended to be more limited and critical – probably because they had less experience of lay help.

Positive evaluations were in keeping with criticisms of other help sources, particularly the GP. The personal relationship shared with friends and family translated to an individualised approach grounded in trust and genuine concern. Many interviewees assigned the lay group a listening and problem-solving role. These could extend to providing practical help, advice, and on occasion talking to others with similar

experiences. Support-giving was commonly identified (n=15) as a second main type of 'help' that could be provided by the lay group. This meant offering emotional support, encouragement, reassurance and comfort, making the individual 'feel better' and 'cared for', promoting self-confidence, and providing motivation in the face of difficult life events and distress. These functions were seen as crucial to recovery and a small number of cases assigned this preventative value on the basis that it had limited the severity of the condition, stopped them from 'festering' and therefore protected them from developing 'deeper depression' (i.d.1). Such factors were considered important for emotional problems and not obtainable from a GP.

I couldn't think of anything really that would've encouraged me more when I was in my position to go seek [formal] help apart from having someone that I know, but those people tend to be, well obviously the people that you know like your friends and your family and so they're the people that you go and see... Its just a case of making them [formal help sources] feel more approachable...and like letting you trust them and believe that they'll be able to help you and that's a difficult thing to be able to convey – that someone who's relatively like a stranger to you is going to be able to help you and that you should be able to trust them (4: male 21yrs).

Female interviewees in particular described how they had benefited from lay help:

(LB: Has talking to them [friends] been helpful?) Yeah it has, its like lifted that little bit of weight off my shoulders...my mind is a lot freer now, it's a lot clearer. It's that they had noticed and I told them about it, the way I was feeling, for me to share my feelings with somebody (11: female, 22yrs)

I had a boyfriend around that stage [of self-cutting] and he actually found out and he helped me stop. We'd like talk and he'd read some of the things I'd written and say I mustn't do it...It did help to have someone to talk to about it. He actually helped me a lot, I mean he wasn't a medical person or anything, but.... (13: female, 21yrs).

For three male interviewees, friends could provide a useful social function, which helped them cope with feelings of distress without directly seeking help.

(LB: What do you do when you feel you're not coping?) Phone someone up, a friend, it doesn't matter. I mean if I'm feeling like crap it doesn't necessarily have to be talking about how I'm feeling, just talking about what happened in 'Eastenders' last night or something like that, just something to distract me (16: male, 19yrs).

In contrast to these positive evaluations, for some interviewees the personal relationship they shared with family and friends was a reason for not seeking their help. Some were embarrassed, and a small group believed their distress was a sign they had let their parents down and so preferred to hide this. Nearly half did not want to impose upon

relationships and burden friends or family, and two avoided lay help-seeking because this created tension.

I didn't want to have to go there and say I do this (self harming) and I'm upset about this and burden other people with it...there was no way I was going to go to them [parents] and say actually it's all been in vain, I've screwed up really bad (19: male, 23yrs).

(LB: Why is it important not to let them [family] see [her depression]?) I don't want to put weight on their mind. I don't want them to worry (11: female, 22yrs).

Several interviewees – in particular males – also disputed whether friends and family could help. Nine believed that the lay group could *not* assist with problem solving, offer advice or practical help. Others believed that friends and family would not listen if approached about mental distress and fifteen thought they would not understand. These were reasons for not seeking lay help.

It is really hard to find somebody that will actually listen to you ... I've tried to talk to friends about it and even my best friend, I've tried talking properly to her before and its just one of those situations where they kind of craftily turn it round and talk about something that's happened to them...I just come up against brick walls really so don't bother trying anymore (12: female, 18yrs).

I imagined going to a best friend but I had a problem imagining him understanding it and properly empathizing with what was going on so I sort of ruled that out (1: male, 20yrs).

Lack of understanding was expected to result in negative responses such as dismissal and stigma, which were the most prominent reasons for not seeking lay help.

Negative responses: dismissal and stigma

Seeking help from friends and family entailed revealing one's distress and therefore confronting directly negative lay beliefs about mental distress and those who suffer from it (Chapter 6). Friends and family were perceived as a main source of dismissive attitudes and stigma and many interviewees feared that they would incur one of these two responses if they attempted to seek help. This fear and past experience was a prominent reason for not seeking lay help at all or on subsequent occasions.

All female interviewees and half of the males believed friends or family may fail to take their distress seriously. They expected to be told to 'pull themselves together' or to have their distress cast aside as a passing phase. Some interviewees believed that lay

members, especially parents, were particularly likely to do this on account of their young age.

(LB: What do you think she'd [respondent's mother] do if you told her you feel hopeless?) Um, she'd probably call me a stupid little idiot. Yeah. She'd say you're not hopeless, it isn't a waste of time, go off and do some revision or something. She can be very flippant sometimes (10: male 16yrs).

More than three quarters of the interviewees also feared that confiding in friends or family would result in negative judgement and stigma, including:

- Being thought of as 'stupid', 'over the top' or non-genuine
- Being regarded as weak – which was a particular theme in males' accounts where they discussed talking about distress with male friends
- Application of a stigmatising label or identity such as 'freak' or 'nutter'.

There was a clear relationship between this fear and interviewees' willingness to seek help from friends and family.

Not many of my friends know. Only one of them knows what I'm like now [about panic disorder]. But I didn't want to tell them. My boyfriend knows and my family knows and that's about it. (LB: Why didn't you tell your friends?) Because they'll probably think I'm a bit weird. I mean they know I worry but not what kind of illness I've got (18: female, 18yrs).

(LB: Did you tell anyone about how you were feeling?) No I didn't, well, yeah, I told my girlfriend I think. That was about it. My mates'd be (.), they'd laugh basically, just say I was a poof or something...I wouldn't tell them no because I'm proud in that manner (21: male, 18yrs).

Interviewees cited the possible repercussions following from being stigmatised as reasons for not seeking lay help. These included the fear of lost friendships or being treated in unusual, potentially undesirable ways.

They [friends and family] might push you aside, so I suppose it's [lay help-seeking] a bit of a gamble to see what they're gonna say, especially so with friends. Family is a bit different because you've always had them but friends, it's a lot more difficult...because then you'll lose friends and you'll feel a lot worse off for it...you would be worried about losing the people who you've got close to you, so it would be a big risk (13: female, 20yrs).

I think they [friends] would change their attitude towards me a lot...there'd be a lot less mickey-taking, stuff like that... they'd probably treat me like a girl.(8: male, 17yrs).

In some cases, fears that friends would not understand and would respond negatively led interviewees to withdraw from friends in order to conceal their distress.

The friend I told, I was talking to her last night, but I don't think she understands what it's like really. I don't think anyone does unless you have it. That's why I haven't told the rest of my friends because I haven't seen quite a lot of my closer friends since my last exam so they're probably thinking why I haven't rang them or haven't seen them and I don't want to tell them why so I'm always thinking of excuses, what can I say not to go out and things like that (18: female, 18yrs).

These themes were not restricted to relationships with friends. Several interviewees also feared negative reactions from their parents and wider family and so did not seek help in an attempt to avoid losing their families' approval and therefore risking stigmatisation by their most significant social group.

(LB: So you were worried about your family's reaction as well?) Yeah, my mum mainly, I mean when I was sixteen my mum used to say 'your dad's got problems with his brain and we didn't understand but now I know it was depression.....so he wasn't insane at all and I really worry about what my mum says and I want my mum to think nice things of me (LB: So you were worried that if you told her [about depression] she wouldn't think well of you?) She'd say to my brother your sister's insane like your dad, you see I know that's what she'd say (3: female, 20yrs).

Many interviewees reported examples of occasions when such negative responses had occurred (Table 7.7) and in particular, of where distress had been normalised by friends and family (Chapter 6). These included flippant dismissive attitudes, which in three cases had also involved friends recommending 'bad coping' techniques such as drinking, smoking and drug use which they found unhelpful and could 'dig them in deeper' (i.d. 13); or being stigmatised and having the legitimacy of the distress questioned either because they were thought to be ungenune or because the lay source did not recognise forms of mental distress as 'real' illness.

These responses tended to:

- create a pattern of subsequent non-help-seeking from lay sources
- reinforce distress and low self-esteem
- discourage or compromise the likelihood of formal help-seeking because distress was normalised/ not legitimised. This could occur even where the interviewee feared they had a problem.

Table 7.7 Examples of negative lay responses to distress

<p>Dismissive responses:</p> <ul style="list-style-type: none">• Flippancy	<p><i>She [friend] was like, 'oh, you don't need them [anti-depressants]' you know, 'all you need to do is go out and buy some clothes, go and do a bit of shopping, do your nails' you know...and that just does my head in so now I don't even talk to her about it... I just rather keep it to myself now and wait 'til I'm on me own and have a good cry or just go to sleep really (9: female, 22yrs)</i></p>
<ul style="list-style-type: none">• 'Bad coping' recommended:	<p><i>My closest friends think that going out and getting rat-arsed one night and you'll feel fine (LB: Is that their suggestion?) Yeah (LB: Do you ever take them up on that?) I try but usually find that after about one drink I feel even more depressed (15: female, 18yrs)</i></p>
<p>Stigma:</p> <ul style="list-style-type: none">• Labels associated with 'mental illness' <ul style="list-style-type: none">• Distress not legitimised/ treated as 'non-genuine'	<p><i>He [father] did say to me once that I'm being a psycho or something like that and I was really upset and it made me cry and my mum said 'oh he shouldn't have said that to you', but yeah, that was a horrible thing to say (18: female, 18yrs).</i></p> <p><i>(LB: What made you attempt suicide rather than talk to someone about how you were feeling?) Feeling that no-one could help me I suppose. Its just me and my girlfriend used to argue all the time and she knew what I was like, I had depression, and the arguing made me so down that I would freak out you know, I would just storm out and just be gone for hours and she just did not care and a lot of the time she just thought I was putting it all on for attention. Faking it basically and I wouldn't – never faked anything in my life. (21: male, 18yrs).</i></p> <p><i>My dad thinks I should just get over it and get on with my life basically because he doesn't believe depression is a proper illness. He believes it's just an excuse for people to be unhappy and things like that, he said...(LB: How does he think you should get over it [depression and panic disorder]?) Just snap out of it and do things (18: female, 18yrs)</i></p>

Summary and conclusions

This chapter has described interviewees’ views about various help sources. Most did not consider the GP to be an appropriate or useful option due to belief that: they deal with physical illness only, lack the training to respond to mental distress; do not provide ‘talking and listening’ therapy (the required form of help); and will only prescribe unwanted medication. Counsellors were regarded as specialists offering talking therapy and problem solving, but this evaluation was not always maintained when interviewees considered counselling in the context of their own distress. Samaritans were thought to offer limited help and to be reserved for those in extreme crisis. Few males had sought lay group help or regarded this as an available help source. Views about how helpful friends and family would be were mixed and the appropriateness of seeking their help

varied according to the context and nature of the distress. Unhelpful lay responses dissuaded some interviewees from seeking further help. The negative meanings associated with help-seeking also emerged in relation to specific help-sources. Taking medication was thought to make distress more 'real' and all forms of help were associated with stigma and weakness. Help-seeking from friends and family carried a direct risk of incurring dismissive or stigmatising responses, which was a major deterrent. Appendix 15 provides further summary.

Negative evaluations of help-sources left interviewees with few or no help-seeking options. Underlying these evaluations was a general scepticism about the extent to which mental distress is treatable and to which help is either useful or possible.

(LB: Do you think you should have to get used to feeling like that [depressed/suicidal]?) Not really no. (LB: Is there anyway around it then?) Apparently so. (LB: Apparently so. What do you mean by that?) According to everyone else there's a way around it so. (LB: Oh right but you don't believe there is?) I don't know, sometimes I do (LB: What do you think could be the way round it?) I don't know, more therapy I suppose (16: male, 19yrs).

This scepticism derived from a number of beliefs related to perceptions of the nature of mental distress and differences between this and physical disorder, negative past experiences of help, and a lack of 'positive stories' about mental health treatment replaced instead by stories of people 'coping as best they can' (i.d. 19). These operated as non-help-seeking beliefs (Table 7.8) and created a poor perception of the possibility of being helped. On occasion, they were difficult to disentangle from cognitive disturbances, such as hopelessness and fatalism, which are symptomatic of illness.

Approximately half the interviewees argued that mental distress is permanent and incurable, even if help is sought, and is a condition one has to 'cope' or 'live' with. Where interviewees did not see mental distress as permanent, they still questioned whether it could be treated, perceiving it to have an uncontrollable trajectory and believing they would have to wait for distress to 'get better' over the course of time – though this could be a long time. Where the possibility of intervention was considered, there was a widespread belief they would have to play the main, if not sole, role in bringing this about due to the personal and internal nature they assigned to distress, which led to the belief that only they could understand, solve and control this. This was contrasted to physical illness where the causes were seen as outside of the individual's control so the need for help was indisputable and help was likely to be successful.

Table 7.8 General 'non-help-seeking' beliefs

'Real' mental distress is permanent/ incurable	<i>I think it's probably something that you will suffer with all your life like you'll have good days and bad days I don't think, even if you do take tablets I don't think you will recover from it (18: female, 18yrs).</i>
Distress related to circumstances is fixed until these change	<i>For me I think it's [depression] caused by realisation that my life is screwed up and this world is screwed up and that's a bit different to some virus somewhere that can be zapped out. I mean what can I do about that? (23: female, 24yrs).</i>
Mental distress has an uncontrollable trajectory <ul style="list-style-type: none"> • powerless to intervene • Has to 'right itself' / recovery is spontaneous 	<i>My view on it [mental health] is that after a while it will go. I'd say its more of a feeling or a phase, something you will eventually go through and you will eventually sort of come out of ...I don't think there's a great deal always you can do... if it's staying around I see it as just it will stay around for a while (1: male, 20yrs).</i>
Mental distress is personal/ internal so only the individual can understand, solve or control	<i>(LB: you wouldn't talk to anyone?) No I wouldn't, like I know it's just me who controls it [depression] and it's [help-seeking] pointless (LB: No-one else could do anything?) yeah, I think its up to you (LB: can't people help you along the way?) No 'cos when I've been miserable in the past its been purely due to my own experiences and its up to me to ward the demons...(LB: so at the end of the day its down to the person to cure their own depression?) Yeah (7: male, 17yrs).</i>

Only six interviewees were convinced that help-seeking was important and beneficial. These were current help-seekers or past cases who in retrospect could appreciate the value of help. Positive evaluations therefore appeared to be associated with willingness to seek, or receive help. These interviewees believed 'help' could shorten the duration of an episode of distress, was a better strategy than trying to solve the problem alone, and should be obtained at an early stage.

(LB: How important do you think it is to go and see the doctor about things [when depressed]?) Oh very important if you want to get better basically because it could go on for years I suppose if you don't do anything...at the end of the day it's the things you've got to do to get better so everything help, I mean, help is important really. Help is good. There's a lot of help out there for things nowadays (21: male, 18yrs).

But much more common was the belief that they could not be 'helped'.

My best solution is always gonna be my tablets in my cupboard... (LB: so you'd chose that rather than help?) At the end of the day um. I know it sounds really crazy but I would...I wouldn't ring anyone, I wouldn't talk to anyone. I would just go home and do that. (LB: Why wouldn't you ring anyone?) I just think that no-one can help me (3: female, 20yrs).

The main findings from the qualitative research have now been presented. In the final chapter, the findings of both the quantitative and qualitative research are discussed within the context of the existing literature and noting further research requirements.

CHAPTER 8: DISCUSSION

Introduction

This final chapter is in four parts. It begins by summarising key findings of the thesis, drawing links between the survey and interview data. These findings are then placed in the context of the existing literature and the contribution of this thesis is considered. The chapter then reviews the methods used, drawing attention to strengths and limitations and reflecting upon the mixed methods approach. The chapter concludes by discussing the implications of the findings for future research and policy.

Main findings

This thesis aimed to: 1) assess the prevalence of help-seeking for mental distress amongst young adults; 2) explore factors associated with help-seeking; and 3) gain a detailed understanding of help-seeking behaviour and reasons for non-help-seeking. A mixed methods approach was adopted to address these. A population survey, screening for probable mental disorder and measuring help-seeking, was sent to a sample of 3004 young adults. Quantitative analyses of these data investigated the first two aims. Qualitative interviews were conducted with 23 survey respondents to obtain narratives of illness behaviour and the understandings informing these, thereby addressing the third aim.

Both components of the research have confirmed that there are high levels of non-help-seeking amongst young adults with mental distress. Most survey 'cases' with probable mental disorder had not sought any form of help and very few (less than 10%) had sought formal help from healthcare sources. Help-seeking amongst respondents with suicidal thoughts was only slightly higher. Qualitative interviews revealed that non-help-seeking was the overwhelming feature of most respondents' accounts. Even those who had sought help had delayed doing so for protracted periods, or subsequently broken contact with formal help-services.

In keeping with the low prevalence of help-seeking identified in the survey, interview data revealed that young adults could identify few 'socially licensed problem-solvers'⁸⁶ to consult for mental distress. They were either critical or sceptical about the available

help sources and were typically left with no help-seeking options as they ruled out each potential source. Most expressed an underlying pessimism about whether mental distress is amenable to 'help' or treatment. They had particularly poor perceptions of a GP's ability to help those with mental distress. In fact, most thought it was *inappropriate* to consult a GP, believing 'mental illness' and 'talking therapy' to be beyond their remit and training. This finding again matched survey data, which revealed a very low prevalence of GP help-seeking.

Severity was the main factor associated with help-seeking among GHQ cases and those with suicidal thoughts. In the survey, the likelihood of help-seeking increased as GHQ score increased. This was more marked for help-seeking from formal compared to lay sources. While this association is in an appropriate direction, it was not simply the case that 'needy' respondents were obtaining help while those with mild distress were not. The threshold for help-seeking was high. GP help-seekers had severe distress (mean GHQ-12 = 9.1) and still only 28% of those with the highest GHQ scores (10-12) had consulted a GP. The survey therefore provides evidence to assert that the iceberg of hidden distress in young adults extends to encompass a sizeable proportion of those with severe distress. Qualitative data confirm this. Interviewees described episodes of non-help-seeking occurring during severe distress, and it was often severity in the form of a crisis such as a suicide attempt, that eventually led to help-seeking. Past help-seeking for mental distress and a perception of having a psychological/emotional problem were also important predictors of help-seeking in the survey, though only just over half of the GHQ cases thought they were experiencing psychological or emotional problems, suggesting a low recognition of problems.

Important sex differences have also emerged²⁹⁷. In the survey, female cases sought more help than male cases. This difference was attributable to their greater tendency to discuss distress with family, friends and other lay sources. The proportions seeking help from a GP were similar. Qualitative findings strongly parallel these data - few men perceiving lay group help to be available. In fact, the data suggest that 'everyday' lay confiding was a norm within the peer and friendship groups of young women, while the tendency *not* to talk was a norm for young men. More often mens' last resort (the GP) also appeared to be their only resort. Sex differences did not emerge in interviewees' discussion of other help sources, though survey data also showed an interaction between gender and GHQ score indicating that male cases had a higher threshold of

severity for help-seeking than females – particularly in relation to help-seeking from a GP.

Qualitative interviews explored lay concepts of mental distress and obtained detailed narratives of illness behaviour. From these data it has been possible to describe an interpretive schema used by young adults to define and evaluate episodes of distress in themselves and others (Figure 8.1) and to devise a conceptual model representing the complex and cyclical process surrounding their help-seeking behaviour (Figure 8.2). These data provide an explanation of survey findings about factors associated with help-seeking. Essentially, interviewees engaged in a struggle to perceive and define distress, with help-seeking only occurring at high levels of severity.

There were two key features of interviewees' schema. First, distress was sharply polarised into two categories, described as 'normal' and 'real' distress. These were separated by a significant threshold. Only 'real' distress was regarded as illness and thought to require help. 'Normal' distress was defined as relatively insignificant and common 'non-illness' that would 'pass' and should be managed by individual coping, or occasionally, seeking help from friends or family. To qualify as 'real', distress or its causes had to be of an extreme, unremitting nature. In fact, 'real' distress was perceived of as a state of not coping (ie. breakdown). A large volume of distress of varying severities was therefore subsumed within the category 'normal' distress. This could include severe depression as some interviewees did not recognise this as illness. Within this schema then, mental disorder could easily be dismissed thus accounting for the high thresholds for seeking healthcare evident in the survey and revealing a disjunction between clinical and lay definitions of need. Also, the polarised framework had clear moral dimensions as 'real' distress was subject to stigma.

Illness behaviour centred round a struggle to negotiate the place of the distress within this framework of 'normal' and 'real' distress. Interviewees were reluctant to define their distress as 'real'. They instead used various strategies to normalise their distress. These involved applying alternative definitions and redefining the criteria for recognising 'real' distress. The process was cyclical as new, persisting or worsening symptoms challenged existing normalisations and required the individual to renegotiate. With each cycle, normalisation could shift the threshold for 'real' distress, and therefore help-seeking, slightly further away and to increasing levels of severity. This meant the gap between young adults' and clinical definitions of disorder and need repeatedly widened.

Interviewees' illness behaviour therefore took the form of a 'cycle of avoidance' – the inevitable consequence of which was non-help-seeking. Relatives and friends contributed to this process by also normalising the distress and so could perpetuate the cycle even when the individual attempted to break free.

Interviews elucidated the factors driving this avoidance - the meanings assigned to 'real' distress and help-seeking. Crossing the threshold into 'real' distress was perceived as a status passage entailing stigma, a sense of seriousness and pervasiveness not attributed to most physical illness, and requiring long-term, undesirable, 'extreme' treatments that would reinforce 'realness' rather than being curative. Adding to these fears was the belief that this status passage was irreversible. Many believed 'real' distress was permanent, or at least would become a permanent part of their biography due to a public 'record' of distress, with lasting stigma. Crucially, as 'help' and 'realness' were inextricably linked, help-seeking was regarded as a pivotal act that would officially transfer the individual across this threshold and initiate the status passage. Help-seeking therefore had significant consequences for self and social identity. Non-help-seeking became the central strategy for avoidance and, ironically, for maintaining 'normality', as the irreversibility of the status passage meant that help-seeking was perceived as 'a backward step' rather than a route to recovery.

The most pervasive theme was stigma. As noted, this was central to the framework of 'normal' and 'real' distress. The concept of 'normal' distress emphasised the 'everyday' and inevitable nature of distress as a part of life. Individuals were expected to cope with this and to be stoical or they could be judged as 'non-genuine'. Against such normality, 'real' distress was a category of 'abnormality' and a negative identity (eg. 'freak') and negative traits (eg. weakness) were assigned to those in this category. Stigma therefore could emerge from help-seeking in two opposing ways: 1) the stigma of being identified with hypochondria or 'faking' 'real' distress resulting in dismissal, and 2) the stigma of having mental illness and of being unable to 'cope' which could lead to ostracism. This presented interviewees with a 'double stigma' and a 'catch 22' situation - only avoided by normalising and non-help-seeking. Stigma thus complicated lay diagnosis *and* was a barrier to help-seeking

If it was a long term problem, then definitely it would change people's opinions of you but then if it's a short term problem and you sort it out very quickly people are just going to say well you were just being stupid anyway so you can't really (.) its not the sort of thing you can (.) win with (1: male, 20yrs)

Specific issues for young adults were also identified. There was a common belief held by many interviewees, their peers and sometimes their parents, that young adults do not suffer from 'real' distress. This stemmed from a notion that young adults' problems are trivial compared to those encountered in later years, so not sufficient to cause 'real' distress. There was also a common observation that young people can be melodramatic about distress or even manufacture this considering it to be 'fashionable' or 'cool'. Young adults' distress was therefore easily normalised as 'teenage angst' or stigmatised as 'fake' making legitimacy more difficult to obtain from peers, parents and even healthcare professionals. This presented obvious difficulties for those who were 'genuine'. Interviews also revealed that transitions such as leaving school, and the instability of young adults' relationships with each other and their parents, disturbed their social networks, on occasion reducing opportunities for lay help-seeking. These findings are now considered further within the context of the existing literature.

Existing literature and contributions of this thesis

Indications that young adults are particularly *unlikely* to seek help for mental distress have remained largely unexplored despite the significant prevalence of mental health-related morbidity amongst this age group (Chapters 1&3). General cross-sectional population data are de-contextualised³⁰⁰ so cannot engage with specific issues confronting young adults. This thesis appears to be the first British study to focus specifically on the help-seeking behaviour of mentally distressed young adults. With the exception of one report containing limited data²⁶, no other qualitative research was identified that has explored young adults' understandings of mental distress and help-seeking.

It has also contributed to the help-seeking literature in this area more generally by providing an in-depth qualitative analysis. Most existing data are survey-based and the qualitative papers identified tend to describe the general views of community samples or patients after help-seeking (Chapter 3, and see also^{301,302}) rather than providing detailed individual narratives of help-seeking behaviour and including those of non-help-seekers. This is of importance given the fluidity of lay beliefs evidenced in these data and elsewhere³⁰². Beliefs may be changed by diagnosis and experience of treatment. The thesis has also explored the more neglected themes from the sociology of illness

behaviour (Chapter 2). An explanatory understanding of reasons for non-help-seeking has been developed, which although focused on young adults and mental health may also apply to other groups and disorders.

Prevalence of help-seeking

Despite a deliberately broad definition of help-seeking and inclusion of a range of informal, as well as formal help sources, less than a third of survey 'cases' with probable mental disorder and under 40% of those reporting suicidal thoughts had sought help. Rates of formal help-seeking were especially low – only 8% of GHQ cases and 15% of those with suicidal thoughts had recently consulted a GP about mental distress – and voluntary sector services had seen even fewer cases. Just one respondent had recently contacted the Samaritans.

These data are broadly in keeping with an Australian-based study of GHQ cases aged 16-19years²⁷ using the same threshold for caseness as in this study, which reported that 17% had sought help from a healthcare professional during a longer period of three months and that young people mainly relied on their family and friends for support. However, in the Australian study, 60% had sought help from friends and family, which is markedly different from this study (26%). The reason for this difference is not clear, but may relate to the definition of help-seeking used and in part could be accounted for by the fact that 60% of subjects in the Australian survey were females who appear to use more lay help (below). Other surveys also report similarly low prevalences of healthcare service use by adolescents and young adults with mental distress^{19,212,213,215}, though they are not directly comparable due to the age range, diagnoses and time period considered.

Accurate comparison with existing general population data is problematic because estimates in other studies tend to refer to help-seeking in the past year and are based on cases identified by diagnostic screening tools, whereas this study measured help-seeking over the past 4 weeks by *probable* cases. It is therefore difficult to use these data to assess whether young adults are especially low consulters. The UK national psychiatric morbidity survey reports higher GP consulting amongst adults of all ages with suicidal thoughts (30% past week) than obtained here (15% past 4 weeks) but this included only those with severe depression³⁷.

This study has confirmed the existence of a large iceberg of undisclosed/ untreated mental distress in young adults. It has also provided a prevalence estimate of distressed

young adults' help-seeking for the UK (others were not identified) and data regarding the prevalence of help-seeking from lay and other informal sources which is an area of omission in the existing literature (Chapter 3). Given the variety of help sources considered, it is possible to conclude that the low prevalence of help-seeking is not explained by young people obtaining help from alternative sources. The findings that 45% of non-help-seekers thought they were currently suffering from psychological or emotional problems and 32% reported thinking "perhaps I should have [sought help]" imply that a reluctance to seek help also underlies this iceberg - not merely poor recognition of distress.

Perceptions of help sources

Interviewees believed that 'talking' and 'problem-solving' were the main types of help required for mental distress and that counsellors or friends and family were the help sources most likely and most skilled to provide this. In contrast, GPs, medicine-taking and the Samaritans received low evaluations, being perceived as inappropriate and/or unhelpful. These findings are broadly in keeping with existing data for adults. Counsellors received the highest endorsement in vignette studies^{178,180,182,184,187}, were positively evaluated in qualitative studies^{191,193-197}, and appear to be particularly favoured by younger adults^{178,181,184,186,188,196}. Similarly, lay sources are endorsed as a popular and preferred source^{22,176,196,217}, again particularly by younger respondents¹⁷⁸. Other studies (mainly qualitative) also report the perception that it may be inappropriate to consult a GP for mental distress, especially where distress is defined as 'non-medical', and low expectations about the extent to which GPs can help and have sufficient time or inclination to devote to patients with emotional problems^{189,193-200}. Fears and criticisms surrounding the use of anti-depressants and other medications are also well documented^{180,187,189,193,194,197,303}.

This thesis has extended existing findings by examining these perceptions in more depth and in the context of interviewees' help-seeking trajectories, illustrating how perceptions influenced help-seeking choices and can alter when applied to real situations. For instance, it was notable that when interviewees considered counselling in relation to their own distress, many became sceptical about whether in fact counsellors are 'experts' and 'talking' does help, and similar findings emerged in relation to friends and family. Perceptions were also situational - interviewees did not consider the lay group to be an appropriate source if their distress related to family problems, involved lay members, or

could negatively impact upon the lay group. Young people experiencing distress in response to common life-events such as family breakdown may therefore be particularly vulnerable. Such findings present an empirical basis from which to critique vignette and other hypothetically-based surveys of illness behaviour^{174,176,178-187}.

It is particularly striking that most interviewees did not consider a GP to be an appropriate help-source for mental distress – even when they regarded it to be ‘illness’. They considered GPs untrained in mental health and associated them and the methods of primary care exclusively with physical disorder. GPs were also associated solely with the treatment of ‘illness’ and so where distress was regarded as personal problems, or assigned other non-illness definitions (as was frequently the case), help-seeking from a GP was again deemed inappropriate. These negative perceptions recurred amongst those interviewed and may explain the low prevalence of GP help-seeking reported in the survey as they were given as direct reasons for not consulting a GP or attending follow-up appointments.

Clearly, these young adults had a limited understanding of a GP’s role. They did not perceive them as a source that could be called upon for emotional support or for social problems which is at odds with images of the ‘family doctor’ as a general social support and help source for psychosocial problems. As noted above, similar findings have been reported for all adults suggesting this is a more general social perception^{194,195,197,199}. The association of GPs solely with physical illness does not appear to have been reported elsewhere, though this observation clearly overlaps with the tendency to regard physical disorder as illness and mental distress as non-illness¹⁹⁴.

A high level of endorsement or recognition of the GP as the main, most accessible, or preferred help-source for mental distress reported in a variety of other studies – qualitative^{193,197} and survey-based^{176,178-180,182,184,187,303,304} was almost entirely absent in this study. In contrast, in a UK survey, two thirds of respondents said they would consult their GP if they were depressed³⁰⁴. Such data clearly conflict with the qualitative finding in this study that most interviewees perceived *no* role for a GP in the treatment of *any* mental distress or illness. Interestingly, some surveys of illness behaviour report that younger respondents were less likely to endorse GP help-seeking^{29,176,178}. This suggests that young adults’ perceptions of the GP may thus be more limited. Alternatively, this difference may demonstrate further the disjunction between hypothetical, ‘public’

accounts obtained in surveys and the in-depth 'private' accounts³⁰⁵ obtained in this thesis in the context of actual narratives of illness behaviour.

Other studies exploring young people's perceptions of primary care focus on satisfaction and barriers to consulting rather than understandings of a GP's role and relate mainly to physical health problems, particularly sexual health³⁰⁶⁻³⁰⁹. Teenagers in one survey reported lack of knowledge about the role and function of primary care in relation to emotional health and counselling services³⁰⁹. In such studies, negative perceptions of GPs and discomfort at consulting appeared to be related to limited experience of consultation and hence opportunities to develop a doctor-patient relationship³⁰⁸. Interviews in this study suggest this may be particularly relevant to unwillingness to consult with mental distress:

(LB: Did you see the doctor as someone you could go to?) Not really, 'cos especially using the student health service you don't really feel that you know a doctor so you don't have a GP that you see every time and so there's no-one that you really feel like you know at all who you have any sort of relationship with that you'd want to be able to discuss it [depression] with (4: male 21yrs).

Factors associated with help-seeking

The majority of published evidence focuses on formal healthcare help-seeking only and explores factors associated with help-seeking in the whole sample rather than in screened cases with disorder (Chapter 3). In contrast, this study offers 'cases only' analysis of factors associated with formal and informal help-seeking in young adults, thus contributing to a limited evidence base. Similarities with existing data have emerged. An important association between severity of mental disorder and help-seeking has been noted in general population^{132,138,140,141,149} and young adult surveys^{14,27,203}. This has also been represented in terms of comorbidity and disability^{14,31,34,129-131,135,145}, but this study has taken this observation further by describing a sex effect in thresholds for help-seeking.

With just one exception²⁷, other studies focus only on formal help-seeking and so cannot compare the factors associated with different sources of help or the strength of associations. In this study it emerged that formal and informal sources appear to be used for distress of differing severity. Those seeking formal (GP) help were more severely affected compared to those seeking help from friends and family. Help-seeking from a GP also showed more association with other indicators of morbidity: suicidal thoughts, poor self-rated general health and usual psychological health. This reinforces the

association of GP help-seeking with high levels of severity but also suggests a link between formal help-seeking and chronicity, which was assessed by the item 'usual psychological health' (Chapter 4). These findings suggest that friends and family are more likely to be consulted in the early stages of distress/when it is less extreme, while GP help-seeking is reserved for severe, possibly chronic disorder, tending not to occur until a high threshold of severity is reached or exceeded. This is likely to relate also to the presence and possible involvement of friends and family as stressful life events unfurl and the occurrence of circumstantial confiding (Chapter 7).

An association between past and current help-seeking appears to have received only little attention by other researchers^{163,310}. This is of potential importance when considering intervention since it suggests that help-seeking may be a learnt or habitual response and that having once 'crossed the threshold' this becomes less threatening. Experiences of 'help' may be instrumental in legitimising and encouraging future consulting. Interviews provided some qualitative evidence of this:

LB: If in the future you felt yourself becoming depressed would you go to the doctor then? I'd go back yeah (.) straight away. I wouldn't even hesitate now, I'd be out right back there. I've learnt from my mistakes (3: female, 20yrs)

The finding that help-seeking was associated with a perception of suffering from psychological or emotional problems is reported elsewhere^{133,137} and the examination of 'perceived need' has reached considerable research attention^{130,147,153,159,161,201,216,311}. However, interpretation of these data is constrained by the cross-sectional approach and rarely appears to have been explored qualitatively as in this study^{195,197}. Qualitative data illuminated the complexity disguised by the somewhat crude variable 'perceived problems' and explained why perceived distress did not guarantee help-seeking (55% of cases considering themselves to have a problem did not seek help). Basically, 'problems' could be accommodated as 'normal' and therefore not requiring help. In contrast to other studies^{129-131,138,141}, sociodemographic factors other than gender (below) were relatively unimportant in predicting help-seeking. It may be that such factors are more influential in middle or later adulthood, which in turn would limit the usefulness of applying models of service use to explore help-seeking in young adults (Chapter 2).

Sex differences in help-seeking

Sex differences in help-seeking have been reported widely. It is suggested that males are more likely to avoid or delay help-seeking³¹² and that sex differences may be most

prevalent in response to mental as opposed to physical problems³¹³. Psychiatric morbidity surveys report a higher prevalence of help-seeking in female compared to male cases among the general population^{37,129-132} and among adolescents and young adults^{15,27}, though contradictory evidence also exists. Several explanations have been offered. It is suggested that women have a psychological disposition to seek help¹⁶⁶, more readily recognise, label and respond to minor illness and emotional symptoms than men^{150,168 166,170}, and that emotional expression in women is 'acceptable'¹⁶⁶. In contrast, it is argued that anxiety and emotionality are not compatible with the male gender role, and that males are socialised to be self-reliant, stoical and tolerant^{166,167,314,315} and without a language for expressing symptoms and distress that does not betray their masculine identity^{300,316}. These factors may result in inexpressiveness^{20,167,314,316-318} and are hypothesised to be of particular importance for young males on the basis that at this age the need to establish and assert a masculine identity is most salient³⁰⁰. It is also suggested that counselling and other such services are perceived as 'women's places'³¹⁴ and that general practices are 'male unfriendly'³¹² while females can obtain more information from peers, popular culture and health promotion literature³¹². However, this is a contested field in which it is difficult to separate empirical evidence from intuitive belief and myth, and where evidence does exist it is sometimes contradictory^{313,319}.

This study provides some evidence to support these suggestions – females sought more help, were more likely to perceive a problem and appeared to have lower thresholds for help-seeking. Qualitative data also indicated that male respondents were more concerned about being perceived as weak and felt less able to discuss emotional issues. The study also extends existing data. First, it provides evidence that young men are less likely to discuss distress with friends and family. Recent research attention has focused almost exclusively on the use of traditional medical services (Chapter 3) and sex differences in the use of a range of help sources do not appear to have been quantified elsewhere. Few young males had sought lay group help and most did not perceive this to be an available help source given the structure and norms of their social networks. The help-seeking resources of young men were much more limited than those of young women. Indications that the lay group deal with less severe morbidity than the GP also implies that females are more likely than males to gain some help in the earlier phases of the illness trajectory and prior to extreme morbidity, which may protect against the development of extreme distress, while males engage in longer periods of non-help-

seeking. Females' greater tendency to confide in friends and family may also have increased the likelihood of cases reaching medical attention before crisis owing to the function of lay referral that was, on occasion, provided by friends and family.

Second, while others have speculated about the possibility that females consult with less severe distress than males^{150 170,201}, actual evidence for a sex effect in thresholds of severity for help-seeking for mental disorder appears to have only been reported in minority disadvantaged populations³²⁰. In this study, male cases had a higher threshold of severity for GP help-seeking than female cases. It is likely that this increases the risk of young men reaching points of crisis, including suicide, without seeking help and this risk may be exacerbated when coupled with their tendency not to acquire lay support before reaching this threshold. Males' higher thresholds could relate to a lack of lay referral. The observation that gender showed only weak association with help-seeking amongst those with suicidal thoughts who were a group with severe morbidity (Chapter 5) adds further support to this, as it suggests that sex differences become less important where distress is particularly severe. However, these survey findings should be interpreted in the context of possible response bias (below).

The sex differences in young adults' help-seeking behaviour observed in this study therefore indicate important differences in the ways that young men and women respond to mental distress and may assist in our understanding of sex differences in the suicide rates of young adults. They may contribute towards explaining why there is a preponderance of male suicide despite a higher prevalence of depression and DSH in women which is a well-known paradox in mental health research^{68,317,321}. However, it is pertinent to note that only a third of young females with probable mental disorder sought some form of help and so the stereotypical notion that 'women talk' while men do not is only partially accurate. It is important that interventions are not aimed solely at young men. Also, similarly low proportions of male and female cases had recently consulted a GP about mental distress. This is at odds with the general impression and psychiatric morbidity surveys showing that females sought more healthcare than males. However the same pattern – increased lay help-seeking but a lack of sex difference in the prevalence of formal healthcare help-seeking for mental distress – was also reported in an Australian survey of young adults²⁷ so this may be a feature of youths.

Lay concepts and beliefs

While it is theorised that health beliefs are central to the interpretation of symptoms and to illness behaviour actions^{86,302} there appear to have been few recent attempts to derive a detailed account of lay beliefs about mental disorder. Those that do exist have focused on ideas about causation, mainly amongst diagnosed patients^{302,322-324}. This thesis has provided a detailed description of young adults' lay beliefs in relation to mental distress. These can be organised into an interpretive schema (Figure 8.1). This describes the polarisation of distress into two distinct categories ('normal' and 'real'), the characteristics, causes and content of these categories, perceptions of appropriate responses to each, stereotypes about people suffering 'real' distress, and theories about susceptibility. Some of these issues emerge in the existing qualitative literature, though not in depth or in relation to young adults. It is noted that distress may be classified as 'problems of everyday living' or normal 'feeling down' rather than 'actual' illness^{191,195,196} or 'real' depression³²³ and similar themes regarding causation and the association of mental illness with lack of personal strength are reported^{192,196,197,302}.

This thesis has also described how these beliefs provided a framework for young adults to assign meaning to symptoms and make help-seeking decisions. Interviewees' dichotomising of 'normal' and 'real' distress resembles the research-based approach of using screening tools to identify 'non-cases' and 'cases', and in doing so draws attention to a considerable disjunction between clinical and lay understandings of where along a continuum of distress the threshold for illness and a need for help lies – 'real' distress being an extreme category. This is illustrated directly where interviewees were prompted to place GHQ caseness within their framework:

(LB: How well do you think they [GHQ questions] summed you up?) Don't know (.) what people read into them I suppose. (LB: What do you think they're about?) um, I don't know, I suppose if you answered in the most negative in most of them then you might be feeling a little bit down (12: female, 18yrs)

The complexity of interviewees' schema illustrates the plurality of meanings that can be attributed to 'depression' or 'distress' and the extent to which these can be negotiated. This illustrates the difficulties of interpreting data such as those collected in 'anti-depressive behaviour surveys'¹⁷²⁻¹⁷⁷ where a standard interpretation of depression is assumed across respondents and researcher.

Figure 8.1: Young adults' understandings of mental distress

	Normal distress		Real distress (mental illness)
<i>Definition:</i>	Non-illness Normal, common, everyday experiences and 'feelings' Sometimes non-genuine		Illness Madness/ insanity/ screwy/ weird Not-coping
<i>Distress included:</i>	Continuum of: Happiness.....Insignificant stress.....Feeling down.....'Over-stress' / severe depression Non-genuine teenage distress (melodramatic, manufactured, fake, or a fad/ fashion) →	T H R E S H O L D	(Severe) Mental illness Breakdown Crisis
<i>Experienced by:</i>	The masses – universal experience/ human nature		The 'select few', 'freaks' – rare and abnormal
<i>Nature and characteristics:</i>	A passing phase, will 'get over it'		Permanent or of long duration Constant, visible, disabling, pervasive Lack of control and function
<i>Causes:</i>	Continuum of common personal problems and life events (part of life) ranging from petty stresses and 'teenage problems' to serious events or an accumulation of stresses.		Major life-events/ traumas – usually irreversible or long-lasting. Brain dysfunction/ genetic disorder
<i>Responses:</i>	Coping alone Pressure relieving strategies Informal support from friends and family		GP Drug treatments Psychiatrist 'Mental home'

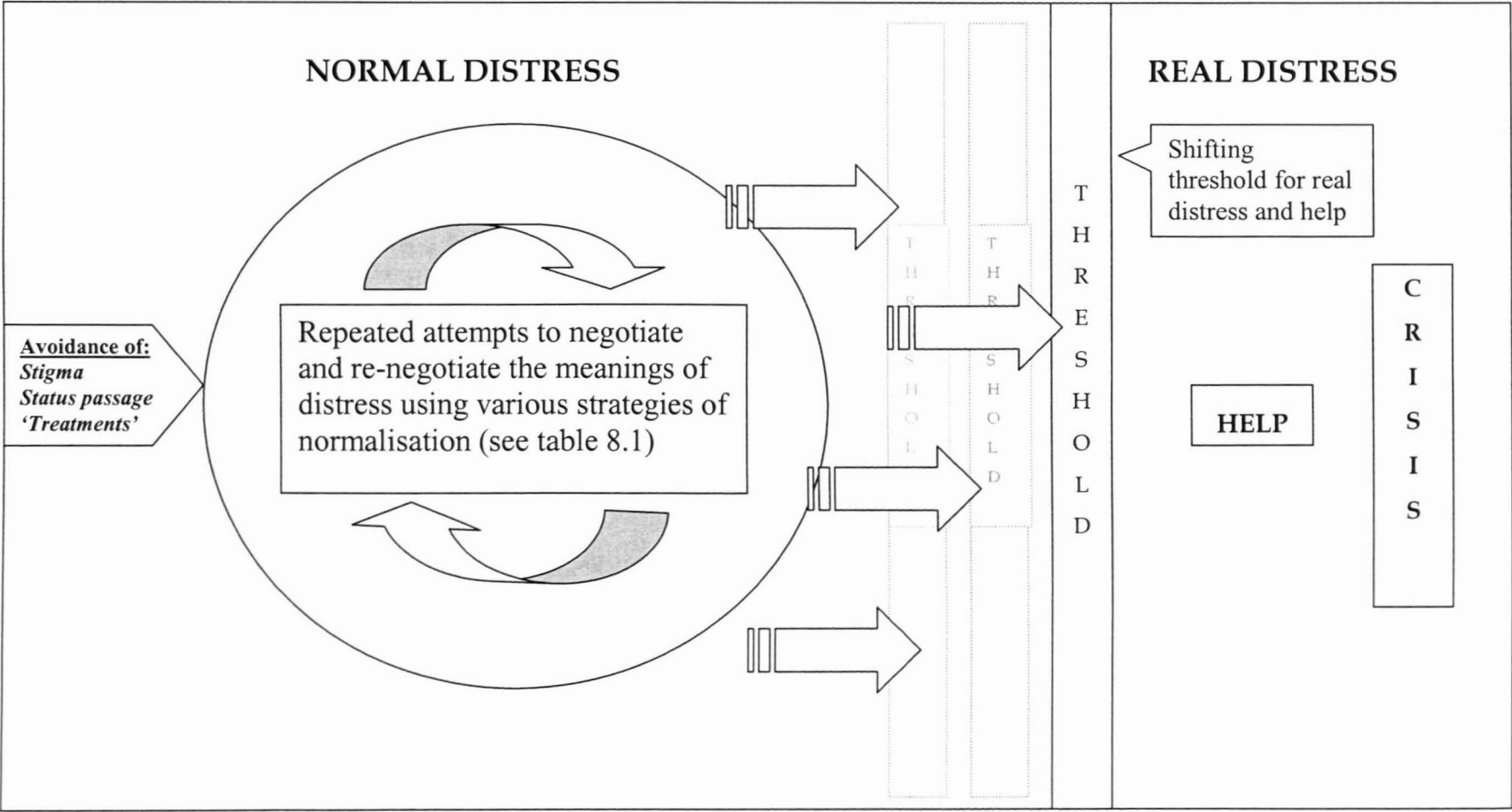
The finding that stigma emerged as a key factor in this framework fits well with sociological analyses which observe that stigma arises from dichotomies according to which individuals with certain characteristics can be set apart and distanced in stereotyped categories as 'non-members' while the 'normal' category is reinforced^{115,325-327}. Stigma is discussed further below.

Illness behaviour

The main contribution of this thesis has been to arrive at an explanatory understanding of young adults' help-seeking behaviour in response to mental distress. This is depicted in Figure 8.2 and evolved throughout the analyses of interviewees' help-seeking narratives. These narratives were complex. The help-seeking trajectories described were far from linear or conclusive but were instead protracted, circular and constantly negotiated. It was impossible to assign interviewees a single help-seeking status – help-seeker or non-help-seeker – and to compare cases because longitudinal accounts could contain a variety of, sometimes conflicting, help-seeking behaviours within one narrative and the fluidity of illness behaviour meant that it was always subject to change. Where help was sought this could be through choice, chance or coercion and so was the outcome of differing pathways.

Figure 8.2 is an attempt to represent this complexity and the text that follows relates to this. Briefly, it depicts illness behaviour as a circular process in which various strategies (table 8.1, below) are used repeatedly to normalise increasingly severe distress in an attempt to avoid defining this as 'real' and requiring help. This process is motivated by the negative meanings associated with 'real' distress and help-seeking (eg. stigma) and results in the threshold for 'real' distress and hence help-seeking being repeatedly shifted to a higher level of severity. In several cases, this continued until the threshold for help was shifted to the point of crisis (eg. *i.d.* 2, 3 & 19)

Figure 8.2: Interviewees' illness behaviour: the 'cycle of avoidance'



Existing theoretical approaches to help-seeking can be revisited in light of the understanding developed in this thesis. Two major approaches were outlined in Chapter 2: models of service use and sociological illness behaviour theory. Models of service use promote a static view of help-seeking by conceptualising it as the outcome of a constellation of quantifiable variables that deterministically predict service use. They describe a 'pre-disposition'⁷² or 'propensity'⁷⁸ to act that is held in balance while help-seeking is determined mechanistically by external barriers and triggers acting upon individuals. The models do not give due attention to the processes for which the gross variables they measure are proxies or by which states such as 'perceived need'⁷² and 'readiness'⁷⁸ are arrived at or defined. Indeed, these processes are obscured as the models provide methodological and analytical frameworks for cross-sectional research and cannot take account of change relating to context.

The data presented in this thesis confirm and extend criticisms of models of service use made in Chapter 2 and by other authors^{82,99,226,328}. The qualitative data emphasise the dynamism of help-seeking and its nature as a complex process of negotiating and re-negotiating 'need' (Figure 8.2). Contradicting the determinism of models of service use and the socio-behavioural model's⁷² focus on demographic and social-structural 'individual' characteristics, the purposeful action of individuals is firmly at the centre of the process of help-seeking. Only seven interviewees said they were impeded by structural, practical, or service provision barriers such as cost, access, or difficulties obtaining appointments, and all seven indicated that these were only of marginal importance. Avoidance of help and denial of illness were far more prominent, challenging the image of 'willing' individuals constrained by structural obstacles. Lay beliefs, the process of interpreting symptoms, the influence of friends and family, and alternative 'coping' responses were central features of interviewees' narratives, yet such factors are referenced but largely unexamined by models of service use.

The qualitative research in this thesis has illustrated the restrictive and reductive nature of models of service use showing that they fail to engage with important processes influencing help-seeking behaviour. It has demonstrated that a focus on socio-demographic variables and structural/practical barriers to explain non-help-seeking, also adopted in psychiatric morbidity surveys (Chapter 3), has clear limitations. Although the thesis focused on mental distress, and many of the issues may be

exacerbated by the particular nature of this, it is likely that these conclusions can be generalised.

In contrast, the understanding developed in this thesis finds much resonance with sociological illness behaviour theory and as such serves as a recent empirical demonstration of this. Key sociological themes and concepts have been directly evidenced including: lay diagnosis as a crucial step in help-seeking and defining relevant sources of help^{84,86,95-97,103}; the tendency to self-treat or cope without help as far as possible^{96,99,113}; the influence of lay networks^{84,97-99}; delay/ denial^{84,86,96}; the complexity of pathways into care^{86,99,190}; and stigma as a barrier to help-seeking^{96,97}. It has also reinforced the importance of examining individuals' behaviour rather than forces acting upon them⁹⁴ and detailed narratives of illness behaviour rather than a single decision of whether to seek formal help⁹⁹.

The theoretical approach taken and data obtained share most similarity with the work of Dingwall (1976)⁸⁶ who advocated examining lay theories and meanings attributed to symptoms in order to understand how illness is socially constructed and hence view illness behaviour as purposeful action. Dingwall devised a model of illness behaviour centred round the process of interpreting symptoms (lay diagnosis) according to lay theories and knowledge and then deciding on appropriate actions and help-sources based on this interpretation. His model improved upon previous conceptualisations^{84,96} by stressing the potential circularity of this process and hence the complexity of pathways into care - particularly where lay networks became involved. He and other authors^{96,97} described the crux of lay diagnosis as an act of deciding whether symptoms were 'normal' or 'deviant' based upon lay theories of normalcy and ideas about 'at risk groups' and situations (Chapter 2).

Parallels between this approach and the data obtained in this thesis are clear. The interpretive processes of individuals proved to be of key importance to interviewees' narratives of help-seeking and, as in Dingwall's model, the central aspect of their illness behaviour. As already discussed, the examination of lay theories and meanings revealed an interpretative schema that revolved round a binary categorisation of distress into 'normal' or 'real' (deviant) and was partly informed by ideas about the types of people and life events associated with 'real' distress. As hypothesised by Dingwall, the categorisation was imbued with social meanings that drove illness behaviour actions in a contextually-bound manner. The data also reiterate the need to conceptualise illness

behaviour as a circular process. In fact, the figure produced attempts to portray a greater dynamism as it became apparent that the circularity referred not only to repeat cycles of re-evaluation as new symptoms emerged or remedial actions proved unsuccessful, but that the very process of interpretation involved a negotiation of meanings that perpetuated a circularity by repeatedly shifting the criteria and thresholds for help-seeking further away, thus allowing further avoidance of illness definitions and actions. Interpretations of symptoms were closely related to interviewees' evaluations of the appropriateness and competence of possible help-sources demonstrating Dingwall's concept of 'socially licensed problem-solvers'.

Lay diagnosis: a cycle of avoidance

Sociologists have long postulated that lay diagnosis is central to illness behaviour^{83,84,86,95-97}. In demonstration of this, interviewees' narratives revolved around an on-going attempt to interpret and negotiate the place of their distress within the framework of 'normal' and 'real' distress. Lay diagnosis was a problem of classification rather than the ability to recognise symptoms, which was the focus of much previous theory (eg.^{95,96}). The problematic experience of lay diagnosis in relation to mental symptoms as one of classification rather than mere recognition of symptoms is also noted in recent empirical literature. Confusion in distinguishing between trivial problems and 'actual' illness appeared to be the main reason why community respondents in one study did not suggest vignette characters should seek help¹⁹⁵ and problems classifying the nature of symptoms are described as fundamental to the help-seeking of patients in a further study¹⁹⁷. However, these studies do not describe how individuals attempted to resolve such difficulties, why they might occur, and how this shaped help-seeking trajectories, and only few studies have actually examined the labels assigned to symptoms by people with mental disorder or by their lay networks^{105,322,323}.

This thesis has therefore contributed to understanding the *process* of lay diagnosis in relation to mental distress and linking this to help-seeking outcomes. It has observed that the boundaries and criteria of 'normal' and 'real' distress are moveable and open to interpretation allowing help-seeking to be repeatedly negotiated, therefore identifying lay diagnosis as a shifting process occurring throughout the illness trajectory. This changeable nature mirrors the fluidity of causal explanations observed elsewhere amongst mental health patients and for which the concept of an 'exploratory map' is suggested to replace that of the 'explanatory model' which has more static

connotations³⁰². In this thesis the key theme characterising this process was normalisation. Interviewees adopted various such strategies to avoid classifying their distress as ‘real’ and to rationalise competing evidence repeatedly shifting the threshold for ‘real’ distress beyond their current state. As help was not sought for distress categorised as ‘normal’, normalisation has emerged as the main explanation for non-help-seeking in this thesis.

Normalisation/accommodation of symptoms has been described in the illness behaviour literature^{95,96,98,274}. It was a feature of Mechanic’s⁹⁶ model of factors influencing illness behaviour and he illustrated this with reference to mental symptoms, suggesting they are especially amenable to competing interpretation because of the continuum of such feelings experienced in society. The normalisation of mental symptoms was described in an early study¹⁰⁵, but as a denial strategy of wives with mentally disordered husbands rather than as an illness behaviour response of the sufferer. Other empirical studies have also provided examples of normalisation in relation to physical symptoms²⁷⁴. This thesis has therefore reported on a well-established sociological concept. It has delineated the processes and strategies of normalisation in relation to help-seeking for mental distress in considerable depth, clarifying how lay diagnosis related to non-help-seeking throughout the trajectory and expanding Mechanic’s theory (Table 8.1). Additionally, it has applied these concepts to the help-seeking of young adults and described how specific beliefs about distress in young adults made their distress particularly amenable to normalisation.

Table 8.1: Key strategies of normalisation adopted by interviewees

<ul style="list-style-type: none">• Rationalising distress with alternative non-illness explanations.• Evoking beliefs about distress in young adults to dismiss distress, eg. teenage angst, ‘non-genuine/ fake distress.• Emphasising or extending the extreme character of ‘real’ distress and the ‘life events’ causing this so that one’s own distress appeared ‘normal’ in comparison (ie. extending the threshold for help beyond current feelings).• Accommodating symptoms to prove that one was ‘coping’ – coping being a sign of normality.• Temporalising/ waiting to see what happened and treating distress as normal until proven otherwise, for example, by failure to recover or crisis.• Assessing need for help according to extreme images of help such as hospitalisation.
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Motivations for avoidance: meanings of 'real' distress and help-seeking

Traditionally, non-help-seeking has been accounted for by 1) failure during lay diagnosis to define symptoms as illness and 2) the occurrence of 'barriers' either restricting the opportunity to seek help or meaning that the costs of help-seeking appear to outweigh the benefits (Chapter 2). There are limitations to these approaches. First, lay diagnosis is more often described than *explained* and explanation mostly focuses on arguments about socio-cultural knowledge and variation^{95,96}. Second, something of an artificial separation has been made between lay diagnosis and help-seeking decision-making, with these being conceptualised as sequential phases. A focus on barriers arises from the assumption that help-seeking decision-making is a separate process occurring once lay diagnoses have been fixed.

The data collected in this thesis draw attention to the need to examine the *meanings* for individuals of possible categories of lay diagnoses *and* also of help-seeking in order to understand illness behaviour. That is, to view both as purposeful social action. Also, it revealed that the interpretation and definition of mental symptoms and decisions about whether to seek help were mutually reinforcing and inextricably linked in circular fashion. Not only did lay diagnoses suggest whether or not distress was real and therefore requiring help, but the act of help-seeking itself played a pivotal role in defining distress, help being one of the criteria for recognising 'real' distress. It was ultimately help-seeking that ('officially') defined distress as 'real'. The decision to seek help was therefore a highly significant social action with meanings far beyond the receipt of treatment.

This thesis has elaborated on these meanings. Ultimately, interviewees wanted to avoid 'real' distress because this was associated with stigma, seriousness, permanence and life disruption. Help-seeking was perceived as an act of confession or admission of 'real' distress, and most significantly, as the point at which one lost control and moved over the threshold from normality to being a diagnosed 'patient', thereby setting the negative meanings of 'real' distress in motion. The 'realness' of distress thus could be resisted, avoided, hidden or denied until help was sought. Help-seeking was thought to initiate an irreversible status passage with threatening treatments and serious consequences for self-concept, identity and biography. Conversely, help-seeking could evoke the stigma of hypochondria if the realness of distress was not legitimised. Interviewees appeared to anticipate themes that have been discussed in depth in the sociological literature

concerned with chronic illness, such as biographic disruption, narrative reconstruction, loss of self, and normalisation as a coping strategy^{274,329-331}. Help therefore could be seen as making distress 'worse' or long-term rather than offering improvement or recovery.

Meanings were differentially associated with specific help sources. For instance, attending a GP and taking medication were especially associated with the notion of a status passage and change of self-concept and social identity, while some interviewees implied that more control could be maintained when using the Samaritans or voluntary counselling services as these were 'less formal'. Non-help-seeking, normalisation and 'coping' were explicable according to these meanings as social actions that could permit denial, avoidance and resistance. This analysis therefore gives reason to argue that it is the meanings attached to help-seeking that should be posited as central to conceptualisation of illness behaviour – not 'barriers'.

The empirical literature on help-seeking for mental disorder does not appear to cover these issues, though some authors studying diagnosed patients' experiences of illness have acknowledged the importance of examining the meanings associated with mental distress and reflect upon their potential to influence treatment choices and self-concept^{302,323,332,333}. These authors also note that very little research attention has been accorded to these issues. Their data provide some reinforcement of the themes in this thesis. Women in one study experienced being prescribed antidepressants as '*a drastic event*' that caused them to redefine themselves from a person with emotional problems to someone with a 'mental illness' who was 'ill enough' to require treatment. They feared that this would result in stigma and many went through a phase of resistance³³². Similarly, in another study, some patients with depression experienced diagnosis as pathologising and stigmatising even where they had previously considered themselves to be 'depressed' because diagnosis established this as 'real' depression³²³. In relation to lay diagnosis, it has been hypothesised that normalisation⁹⁶ and reluctance to perceive oneself as mentally ill may occur due to stigma¹⁹¹, and that the fluidity characterising individuals' attempts to account for their distress may be an avoidance strategy where the identity of the illness "*is unwelcome or carries with it socially unacceptable connotations* (pg473)³⁰². It is suggested that longitudinal data are required to explore such possibilities³⁰². The data in this thesis go towards providing this as several interviewees' detailed long trajectories of distress.

Stigma

Stigma has been linked with mental illness in a large literature – impressionist and empirical - spanning a long period of time^{326,334}. Studies continue to provide evidence of this, particularly in relation to schizophrenia and addictive disorders, but also depression^{303,326,334,335 185,188,324}. Most research attempts to quantify this in survey or vignette studies, for instance by using attitude scales, but it has been observed that closed questions tend to produce more positive responses while open questions yield negative views³³⁴. The data collected in this thesis provide a naturally occurring description as interviewees were not prompted to discuss stigma when asked about their concepts of mental distress.

Sociologists have observed that most stigma tends to be attached to disorders affecting the mind and which fall into the category of deviance rather than physical disability³³⁶ and stigma is also offered in sociological illness behaviour theory, particularly in relation to mental illness, as a help-seeking barrier^{96,97}. Early studies provide empirical evidence of stigma associated with receiving help for mental disorder¹¹⁴. More recently, fear of social disapproval and embarrassment have been volunteered or endorsed as barriers to help-seeking in general population surveys^{130,133,147,155-158,303} and surveys of young people²². Likewise, stigma has emerged in qualitative studies of help-seeking for mental distress as a reason for not disclosing symptoms or accepting treatment^{189,191-193,195,196}. Further, stigma has appeared as a barrier to recovery from mental illness³³⁷ and to compliance with medication³³⁸, as also apparent in this study.

However, the relevance of stigma to help-seeking for mental disorder has also recently been critiqued by Prior et al¹⁹⁵ who argue that the concept is applied popularly and indiscriminately, potentially obscuring other important factors. They argue that in their own study of lay attitudes to help-seeking for mental disorder, difficulties classifying distress and deciding where this constituted illness were more important than stigma, which did not emerge as a key theme. These conclusions clearly conflict with those of this thesis. This may be because Prior et al collected data from community samples (who may or may not have experienced mental distress) engaged in generalised focus group discussions. This thesis also gives some indication that stigma is accentuated in the context of young adulthood. The difference may also be explained by the fact that Prior et al focus on stigma solely as a 'barrier' to disclosure, while this thesis has moved beyond this with a more interactive analysis of the influence of stigma throughout the

illness trajectory. It has revealed that stigma also permeated individuals' interpretive processes as they attempted to define distress and assess the need for help – that is, the complex processes of classification that Prior et al allude to.

In support of this interpretation, there is a striking congruity between the data collected in this thesis and Goffman's³²⁷ classic exposition of stigma. Goffman accounts for stigma in terms of normative expectations about 'identity' and 'being' held in society. He argues that society establishes means of categorising its members and that the meanings attached to each category define the moral status of those contained within. Stigma emerges in circumstances where signs indicate that the attributes of a person (their actual identity) deviate from what is normatively expected (virtual identity) and communicate something negative about the individual. If this discrepancy becomes apparent, the individual is 'discredited' and placed in a category of 'undesired differentness' from those upholding expectations ('normals'). A 'stigma theory' is then constructed to explain this inferiority and generate a 'stereotype' of the stigmatised individual. Where signs of stigma are less visible the individual remains 'discreditable' until these become evident.

The framework of lay beliefs described in this thesis make sense in light of these concepts. 'Real' distress contradicted the expectation that distress should be self-limiting and manageable. Sufferers were perceived as 'rare' and 'strange' and placed in a category clearly separated from 'normal' distress. Beliefs about susceptibility appear as a stigma theory and often involve the imputation of weakness or personality defects to those with 'real' distress. It also follows that a young adult with 'real' distress may incur particular stigma due to the normative belief that young adults do not suffer 'real distress' and some evidence of this emerged in the data. Goffman himself is clear that mental disorder is of a discreditable nature and references Yarrow et al's¹⁰⁵ study of wives' responses to their mentally ill husbands to illustrate his discussion.

Discussing the various consequences of stigma, Goffman introduces the concept of personal identity and biography, stating that each individual is "*an entity about which a record can be built up*" (pg80). This is a record of social facts that are attached to personal identity, "*becoming then the sticky substance to which still other biographic facts can be attached*" (pg74-5). Essentially, Goffman explains that once discovered, stigma becomes established as part of the individual's biography and therefore a fixed part of personal identity. This spoils the current and future reputation of the individual as the individual

becomes 'type-cast' as 'other' so that even normal behaviour becomes reinterpreted in light of the stigma and this diffuses throughout all spheres of social life.

Identity and biography emerged spontaneously as themes when interviewees discussed the possible outcomes of help-seeking as an act that would make their distress 'publicly real' and they described these in terms fitting Goffman's own description. They anticipated that being a 'person with real distress' would entail a public change in identity represented by patient status and resulting in a permanent 'record'/'special mark' and being 'watched' by others in 'everything' they did (Chapter 6):

If I did [seek help] I imagined it would become really serious and my family would know all about it and there'd be no turning back or if I didn't I could just try to keep hold of being normal as far as I could and keep my life slowly churning along and try to get over it and that's what I decided. I saw it as the best thing I could do really if I ever wanted to come through it without it changing my life forever. (23: female, 24yrs)

Such beliefs that help-seeking would in fact give distress permanence show striking similarity with Goffman's further observation that attempts to 'correct' a stigmatising attribute do not return the person to the category of 'normal' but instead merely transform them from a person with stigma to person with a record of stigma: *"the effort to conceal it or remedy it becomes 'fixed' as part of personal identity"* (pg84).

Goffman argues that those with a discreditable stigma are faced with the dilemma: *"to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case to whom, how, when and where"* (pg57). He suggests the common response to this is 'passing' – an art of impression and information management through which the individual purposively acts to control their image by manipulating or concealing the signs that indicate stigma.

Methods of passing include:

- Avoiding social contact.
- Avoiding stigma signs. Here, Goffman cites the example of disability aids, explaining that since these convey existence of a stigmatising attribute their use may be *"rejected"*.
- Using dis-identifiers (signs of normality) to throw doubt on the stigma definition
- Presenting stigma signs as examples of a differing attribute in order to manipulate the meaning assigned to these and *"employ an unconventional interpretation"* (pg21).

Goffman suggests passing may take the form of a 'cycle' but that this always carries the threat of discovery and may be halted by some discreditable attributes that make such passing impossible. The conceptualisation of illness behaviour as a cycle of avoidance appears to fit well with this notion of 'passing' and it is notable that interviewees referred to help-seeking as an act of confession and some to their distress as a 'secret'. Severe symptoms, seeking or receiving help, and use of medication were signs of 'real' distress and hence stigma within young adults' framework of distress. It was therefore these signs that required concealment, avoidance or manipulation to ensure that public and self-identity was not discredited. Several methods of passing were apparent and some were interpretable as strategies of normalisation. For instance, 'coping' was used as evidence that distress was not real, and alternative interpretations were repeatedly applied to symptoms. Non-help-seeking could be viewed as the main act of 'passing' - 'help' being a stigma sign because a need for this revealed a deviation from the norm.

Goffman also discusses how close family members may contribute to passing. As evidenced in this thesis, he notes they may respond by 'normalisation' - particularly where they might otherwise suffer a stigma due to their association (courtesy stigma). Reminiscent of the finding that lay contacts perpetuated the cycle of avoidance, Goffman describes how 'intimates' *"not only help the discreditable person in his masquerade but can also carry his function past the point of the beneficiary's knowledge"* (pg120).

An important aspect of Goffman's theory is the reflexivity that he assigns to individuals. He asserts that having been socialised as a member of society, the stigmatised individual shares the same beliefs and standards as wider society and so not only feels shame and self-disapproval at their 'felt identity', but is also aware of the social consequences of stigma. In this thesis, 'real' distress was a threat to interviewees' private self-identity as well as their public identity and perceived as both a social and personal failure. Such reflexivity may also account for interviewees' perceptiveness of the potential consequences of stigma. As indicated above in relation to biography and identity, some appeared aware of and anxious to avoid phenomena related to stigma and discussed in great depth in the sociological literature such as master status, secondary deviance and the 'stickiness' of labels³³⁹⁻³⁴².

Reflexivity means that stigma can involve a change in self-conception. Goffman conceptualised this as embarking upon a 'moral career', which he suggested may elicit 'normification' - that is, the individual's attempt to deny their differentness. One means

of achieving this is by 'stratifying the category of the stigmatised' to find individuals with 'evidently more stigma'. By then stigmatising these individuals, separation can be achieved and a closer association of oneself with 'normals' on the basis that "*the more allied the individual is with normals the more he will see himself in non-stigmatic terms*"(pg131). This is entirely compatible with interviewees' perception of help-seeking as initiating an irreversible status passage. They attempted to avoid embarking upon this by normalising their distress. One means of this was a search for examples of more extreme distress in others to shift the threshold of need away from them and normalise their own distress in comparison (Chapter 6).

This extended example has reinforced the explanatory potential of 'stigma' where this is applied within an interpretivist framework and as an analytical concept rather than a singular barrier to help-seeking.

Discussion of methods and conceptual issues

This section focuses on the methods adopted by reflecting upon the usefulness of a mixed methods approach, reviewing methodological strengths and weakness and considering an important conceptual issue surrounding any inquiry into help-seeking – the construction of non-help-seeking.

Reflections on the mixed methods approach

This study combined quantitative and qualitative methods. Each method contributed differing yet important levels of understanding. The survey component provided data about the scope and patterning of non-help-seeking and the qualitative component explored illness behaviour and obtained rich contextual description thus offering understanding of the reasons for non-help-seeking, allowing this to be conceptualised as a process and locating it within the context of young adulthood. The mixed methods approach therefore allowed quantitative and qualitative approaches to be used in complementary fashion to increase the scope of the research, which was important given its exploratory aims in response to a lack of existing research. However, the two components were not merely 'self contained'²²² studies conducted in parallel, but were combined at a number of levels.

The survey questionnaire was developed using qualitative methods. During data collection, the survey was crucial to facilitating the qualitative research because it provided both a descriptive backdrop and a large sampling frame with details of each respondent from which to sample. Patterns in the quantitative data and responses to open-ended questionnaire items suggested issues and identified individuals with particular characteristics or viewpoints to explore. This also increased the opportunities for maximum variation sampling and following-up of apparently 'unusual' cases. Crucially, the survey allowed non-help-seekers as well as help-seekers to be identified for in-depth interview, and individuals currently engaged in the processes of interpreting their symptoms and making help-seeking decisions rather than being restricted to the retrospective accounts of those who had sought help. This does not appear to have been achieved in other qualitative studies (Chapter 3).

An attempt has been made at the level of interpretation (this chapter) to draw on the two sets of data in parallel where possible and to flag consistencies. This can be viewed as a form of triangulation²²⁰. Qualitative findings have been used to explicate and offer interpretation of quantitative findings. In reverse, some quantitative findings may hint at the generalisability of qualitative themes. For instance, exceptionally low rates of help-seeking from a GP gives reason to suspect that the negative perceptions reported in interviews are widespread. The compatibility of the two sets of data suggests enhanced credibility of each.

Contrasts between the two approaches are also enlightening. The qualitative interviews demonstrated and grappled with complexities that were overlooked or simplified by the cross-sectional survey approach. In particular, the longitudinal data they provide reveal the difficulties of assigning a single help-seeking status to cases at differing phases in a changeable process. This issue is discussed further below.

The survey

The population-based approach meant that the survey was based upon a diverse, cross-sectional and representative sample. It was drawn from a large population and consisted of subjects from a wide mix of socio-economic backgrounds and from inner city, urban, suburban and rural areas. The survey was not primary care-based and so reached individuals who had not made contact with services as well as help-seekers and therefore could explore hidden morbidity. The data obtained regarding the prevalence

and patterning of psychiatric morbidity are similar to other regional²⁹ and national³⁰ UK data indicating that the analyses are based upon a representative group.

Response rate and sample size

The survey response rate was low (48%). This may be explained by the subject matter²²⁸ (mental health) and also the age group researched (a mobile, young population). This mobility may also have contributed to inaccuracies in the health authority register resulting in undelivered questionnaires. This could only be estimated. An attempt to assess the respectability of this response rate against other young adult surveys is hampered as many such surveys are conducted in a school setting during class time yielding high response. However, studies of non-response have noted the difficulties of recruiting younger adults, particularly young men, in population surveys³⁴³, including those examining psychiatric disorder³⁴⁴ and a recent survey of young adults aged 17-18 years focusing on generic issues surrounding 'problems' and help-seeking attained a response rate of just 37%³⁴⁵. This, alongside other examples of low response in young adults^{183,346,347} suggests that the response rate achieved in this study is reasonable.

Nevertheless, response bias is a possible limitation of the survey. Literature suggests that it is usual in surveys of this nature for non-responders to have higher levels of psychiatric morbidity³⁴⁸ and it is possible that those unwilling to seek help are also unwilling to self-report symptoms on scales such as the GHQ or to respond to questionnaires. Limited data were available to assess possible non-response bias in this study, but non-responders were more likely to be male, living in poorer areas, and older (which may reflect the greater mobility of school leavers). As males appear less likely to seek help when distressed, it is likely that the survey will have produced conservative estimates of help-seeking.

In the absence of further data, a crude attempt was made to estimate other possible non-response bias by comparing the characteristics of early and late responders on the assumption that those not responding until a second reminder were similar to non-responders (Chapter 5). The sociodemographic characteristics of late responders were in keeping with those of non-responders strengthening the case for this assumption. There was little difference between early and late responders in terms of help-seeking or GHQ caseness providing some evidence that levels of response may not have biased the results. If anything, late responding males had a lower mean GHQ score indicating that

males with less severe psychiatric morbidity may be under-represented in the sample. If such males are equally as likely to seek help, this may have led to an exaggerated estimate of the difference in GHQ score between help-seeking and non-help-seeking males, though the qualitative data tend to confirm that those with less severe morbidity are also less likely to seek help. As noted above, the prevalence of morbidity in this survey was similar to that reported elsewhere, offering further indication of its representativeness.

The relatively small sample size in this study imposed some limitations upon the power to detect associations and their strength. This was particularly the case for multivariable analysis and help-seeking from a GP because of the low prevalence of cases seeking such help (Chapter 5). These findings should be interpreted with caution, but given the absence of other data in this area, the findings are of exploratory value and have identified areas for further research.

GHQ misclassification

The accuracy of prevalence estimates and analyses of factors associated with help-seeking may be affected by misclassification of caseness. This is more problematic where using a probabilistic screen (the GHQ) rather than a clinical, diagnostic questionnaire³⁴⁹, though the GHQ is well validated and recommended for case identification^{218,252}. Use of the GHQ also creates some difficulties in comparing the results obtained here with larger-scale surveys using diagnostic interview schedules (Chapter 3). Steps were taken to identify possible chronic cases missed by the GHQ (Chapter 5). This suggested that a small number had been missed, of whom some had sought help, though the number was too small to have a great affect on estimates of help-seeking. They were not excluded from the qualitative study as one was recruited for interview (*i.d.* 14), whose chronicity was confirmed.

A threshold score of 4 was used (rather than 3) in an attempt to minimise false positives (Chapter 4), but there was evidence that some misclassification had occurred from those selected for interview. Two interviewees had been misclassified (*i.d.* 6 & 8). One of these had a GHQ questionnaire score of 10 but scored 0 at interview. Qualitative exploration implied that he was neither a mild nor transient 'case', but had completed the GHQ on the basis of feelings at one specific moment in time and not over 'the past few weeks' as instructed.

(LB: I noticed [remarking on completion of GHQ at interview] that you put 'same as usual' quite a few times?) yeah um you know (1) I'm quite happy with things at the moment so (.) you know (.) things generally chug along quite nicely (1) nothing special happening nothing to worry about and to you know be extremely stressed. (LB: so same as usual for you is neither one way or the other really is it? Neither happy nor miserable?) Yeah, it's 'alright'. (LB: do you remember how you filled it in last time - when you filled out the questionnaire?) Last time when I filled it I think I remember it I had a quite a (.) really difficult maths homework to do beforehand so I wasn't in a very good mood so yeah, a lot of three and four categories were put in I think (LB: why did you say that was, what were you doing?) um (.) well I do after I've finished you know maths um I can't (.) you know if its something really difficult I do get into quite a bad mood so ((laughs)) (LB: so its all the fault of your maths homework?) Oh yeah, yeah (8: male, 17yrs)

False positives pose problems for the interpretation of estimates of non-help-seeking but were less problematic in the context of qualitative research where the misclassification was apparent and data about general beliefs could be obtained. Particularly pertinent is the suggestion that misclassification does not derive solely from 'errors' in questionnaire design but could also be a product of the illness behaviour of individuals – false negatives being those individuals who underestimate or are reluctant to express emotional symptoms and false positives those who emphasise emotions³⁴⁹. 'Caseness' was examined with more accuracy in qualitative interviews using the CIS-R schedule. Of the 17 interviewees screened, 10 scored above the CIS-R threshold of 12. Others were probable past cases.

Limitations of a cross-sectional design

As evident from the qualitative data, help-seeking is a complex, changeable and often protracted process and survey cases are at a particular phase in their illness and help-seeking trajectories. A cross-sectional survey cannot adequately take account of trajectory³⁵⁰ and is therefore limited in the extent to which it can disentangle such complexity.

In a cross-sectional survey, help-seeking becomes categorised as a binary outcome. Cases are assigned a 'help-seeking status' ('help-seeker' or 'non-help-seeker') according to their help-seeking during the specific period of time measured by the questionnaire. The qualitative data demonstrate the artificial and reductive nature of such a categorisation. Many interviewees described long-term help-seeking trajectories in which they alternated between help-seeking and non-help-seeking or took different actions in response to differing episodes (*eg. i.d. 3, 9, 23*). Some 'non-help-seeking' interviewees in the early phases of an illness trajectory were in the process of help-

seeking decision-making and may have been more appropriately described as 'potential' consulters - their illness behaviour yet to be determined (*eg. i.d. 11*). Further, the term 'help-seeker' implies individual choice and action and while this accurately describes some interviewees' pathways to care (*eg. i.d. 14*), others had become 'recipients of help' - sometimes despite efforts to avoid this (*eg. i.d. 3, 16*). A cross-sectional approach therefore cannot represent adequately issues of motive, timing and context, which surround and characterise illness behaviour, yet this approach typifies most recent research (Chapter 3).

Cross-tabulations also indicated that a small number of cases were misclassified as non-help-seekers due to the short time-frame within which help-seeking was measured in this study but they were few in number so their exclusion had little affect. These were respondents who were currently using medication prescribed by a GP and so appeared to be engaged in a treatment programme. Other surveys measure help-seeking over the longer duration of 6 months or a year (Chapter 3), but this also is problematic since the qualitative research revealed that help-seeking was often unstable and frequently discontinued. 'One off' help-seekers could therefore be classified as 'help-seekers' despite subsequently engaging in longer periods of non-help-seeking.

The cross-sectional approach also places some limits on the interpretation of findings. For instance, the apparent association between past and current help-seeking may in fact relate to a continual process of help-seeking in response to one significant episode. In this case, the variable 'past help-seeking' would be separating chronic or severe cases from transient disturbances, simply replicating findings showing an association between severity, chronicity and help-seeking (above). Interpretation of the association between perceived problems and help-seeking is also problematic since this perception may be a product of help-seeking and diagnosis rather than a factor causing help-seeking. These issues could be unravelled using a longitudinal approach, which could also measure the outcome of caseness, distinguishing transient distress from the more pervasive, and therefore refine the identification of cases requiring help.

Summary

The survey was undertaken to discover rates of distress and help-seeking amongst young adults and was essential in providing a statistically representative grasp of the scope of the problem as a first stage in this mixed methods design. Its cross-sectional nature was, however, an imperfect way to explore help-seeking. It entailed categorising

a dynamic and fluid process into a quantifiable 'status' as though this were a single act and may have over-estimated the extent of non-help-seeking by including transient or mild cases, measuring help-seeking over a short time period (4 weeks), and failing to separate potential help-seekers at the start of an illness trajectory from non-help-seekers who have endured symptoms over a period of time without seeking help, though the point at which a potential help-seeker becomes a non-help-seeker is a further conceptual problem. Quantitative survey approaches in psychiatric research have also been criticised for describing 'a narrative of variables rather than a narrative of acting subjects' on the basis that 'cases are characterless'³⁵⁰. These limitations were addressed by proceeding from the survey to in-depth qualitative inquiry.

Qualitative interviews

The use of qualitative methods in this study made it possible to explore reasons for the findings of survey. It has provided rich insights into the perspectives, beliefs and experiences of distressed young adults. These guided the research process and hence the understanding derived reflects the priorities of young adults. Respondents appeared to welcome the opportunity to discuss their experiences and textual accounts and drawings included on a selection of questionnaires suggest some felt constrained by the survey format (Appendix 16). The qualitative method also allowed the illness behaviour narrative to become the unit of analysis and so could explore the complexity of this as a process and contribute longitudinal data. The social context within which this narrative occurred and the social interactions shaping it were also amenable via qualitative methods and proved important to understanding help-seeking.

A broader and more robust understanding was achieved by exploiting the opportunity to interview a range of cases. Past and current cases were interviewed as there were benefits associated with each. Past cases allowed exploration of a complete illness behaviour trajectory and its outcomes with individuals whose cognition was not affected by a high level of distress, which on occasion was problematic when interviewing current cases. They offered reflective and retrospective accounts. While these may be viewed as 'constructed' accounts, the phenomenology of Schutz (1967)²⁷⁷ argues that such accounts may be preferable on the basis that an individual can only fully understand and articulate meaning from a reflective glance. Past cases could also reflect on how past illness behaviour or help-seeking experiences might shape their responses

to future episodes of distress. Interviewing current cases, however, made it possible to capture and observe aspects of lay diagnosis and help-seeking decision-making in real-time and in context. Further, current cases at differing stages in their illness and illness behaviour trajectories were recruited allowing a more longitudinal view of illness behaviour.

The data obtained were rich and complex. The range of cases sampled resulted in a dataset that contained cross-sectional, longitudinal, current and reflective accounts. Also, many interviewees offered both hypothetical and 'real' data, which had to be disentangled. Longitudinal accounts revealed shifts in beliefs through experience. Analysis was therefore challenging and time-consuming.

Validity and reliability

There is increasing acceptance that qualitative research should be critically evaluated to maintain quality and avoid impressionist work²⁹², but much debate about how quality can be judged and what constitutes methodological rigour in qualitative research^{287,292}. Within this context, there have been several attempts to devise checklists or other 'standard' criteria for evaluating qualitative research^{284,293-296}. Although the value of this approach is debated³⁵¹ some commonalities emerge. These include the requirement that research methods are applied systematically and consistently and are transparent so that their adequacy can be scrutinised, and the notion of trustworthiness or plausibility in the data collected and the interpretations generated from these. Essentially, these criteria are concerned with reliability and validity but operationalised in terms befitting the nature of qualitative enquiry^{287,292}. These require:

- Completeness in data collection, including the search for new or different cases to achieve maximum diversity and until understanding has been achieved that can account for all cases.
- Comprehensive data treatment²⁹², that is, consideration of all data, including the contradictory, to avoid anecdotal reporting of selected views only and hence bias or incomplete explanations.
- Consistency in the way that meanings are attached to data within and across researchers.

Several strategies were employed in this study to ensure quality control:

Data collection and management

Interviewees chose where the interview took place. This allowing them to select the environment in which they felt most comfortable and which offered them privacy. Most chose to come to the university. Attempts were made to establish rapport through causal conversation before commencing the interview. All interviewees appeared at ease but one (*i.d.* 12) whose interview was conducted at home was inhibited on occasion because her parents were home during the interview. Interviews were tape recorded in full and transcribed verbatim to ensure all data were available in raw form and not according to the researcher's reconstruction of these^{291,292}. Computer software was used for data management and retrieval, facilitating comprehensiveness and the ease with which it was possible to look across the whole dataset^{284,292}.

Grounded theory and 'constant comparison'

Principles of grounded theory were employed to provide a systematic approach (Chapter 4). Data collection and analysis took place simultaneously and in iterative fashion over five main batches of interviews. This ensured that findings emerged from the data through an inductive process and that codings, concepts and understandings could be verified and increasingly refined. Purposive sampling was used to achieve breadth and to refine emerging understandings and continued until the main categories of respondents had been represented, attempts had been made to explore deviant cases, and similar themes re-emerged. The constant comparative technique was employed in data analysis to ensure comprehensive and systematic data treatment and with the aim of theory building. A pure grounded approach was not achievable within the bounds of this research since this would entail obtaining multiple 'slices of data'²⁷⁸, triangulation of sampling and method, follow-up interviews with some respondents, and notably prolonged contact with the field.

Investigator triangulation

With the aim of improving reliability in the collection and interpretation of data, early interview transcripts were read by all supervisors (DG, JD, DS) and a general discussion followed of the themes within and areas to be explored in further interviews. A random selection of transcripts were also coded independently by LB, JD (a social scientist) and DG (an epidemiologist with clinical psychiatric training) as a means of examining inter-rater reliability – that is, the consistency with which data are assigned to the

categories^{290,292} and hence that interpretations correspond with the data and are applied in a methodical way. These codings were then compared and discrepancies and additional codes discussed. Adjustments were made to refine the emerging coding frame³⁵¹, though these were only minor, as overall there was much consistency - most differences relating to choice of terminology rather than content. This process was repeated by LB and JD at varying stages with sections of coded data to check subcodings and interpretations of relationships within categories.

Exploration of 'negative' cases

Having established some common themes and preliminary patterns, attention was given to 'negative cases' - 'cases where things go differently'²⁹¹. These helped to illuminate and refine the understanding of illness behaviour depicted in Figure 8.2. In these data, negative cases took two forms: 1) where respondents expressed views opposing the common trend identified in other interviews; 2) where respondents reported episodes of help-seeking. These were obtained by searching the collected data for deviating views and purposively sampling those whose questionnaire responses suggested they might be a 'negative case' - for example, help-seeking males with an apparently direct route to help.

Negative cases were particularly important at the level of axial coding. The contexts and events surrounding help-seeking were examined and compared with episodes of non-help-seeking in an attempt to identify key differences in circumstances and belief that might account for them. For instance, episodes of help-seeking demonstrate how the cycle of avoidance was broken. Mainly, this was due to a crisis event (eg. suicide attempt), or other public exposure of symptoms, such as discovery of self-cutting, or an uncontrolled display of emotion. Visible and somatic symptoms such as weight loss/loss of appetite and those of panic also provoked help-seeking where 'feelings' of depression did not. Such data provided insights into the process and limits of normalising and negotiation of 'realness'. Significantly, it was parents or other older adults such as employers, rather than friends that referred or brought the individual to help. The issues surrounding the legitimacy of young adults' distress appeared to be less pertinent here than amongst friends. Several help-seekers also had a parent or other family members who had been treated for mental illness. This appeared to create a help-seeking environment by minimising the threat of stigma from the close lay network, promote a more medicalised understanding of mental distress, and provide a

knowledgeable and understanding informal help source. The centrality of stigma to non-help-seeking was also underlined by the relatively lower importance assigned to this in a small number of cases where help-seeking was direct and voluntary.

Presentation of data

Steps were also taken to minimise researcher bias in the presentation of results. Contextualised quotations are presented to support and illustrate the themes and concepts described. These provide transparency of analytical claims and *apparent validity*²⁹¹. Extracts were used from a wide range of respondents rather than drawing heavily on a few cases ('fair dealing'²⁸⁷). Some degree of enumeration is also used throughout to give an overall impression of the generality of the themes described^{225,284}, but mainly this is described loosely using terminology such as 'most', 'many' and 'some' as using a semi-structured and grounded approach means that inevitably the same questions are not asked of all respondents. Some areas were introduced at later stages of data collection and as the analysis become more refined 'saturated' themes were not intentionally explored in great depth with later respondents.

Reflexivity

It is acknowledged within the qualitative research tradition that the researcher is both the tool of data collection and part of the social world that they study. They cannot 'escape' the social world in order to study it and as such become an 'active participant' in the research process²⁷⁵. The researcher brings 'common-sense' knowledge, personal and intellectual biases, experience, prior assumptions and characteristics such as age, sex and professional status to the research process^{275,287}. This may affect the questions that they ask, their interpretation of data, and also the research subjects with whom they interact. While such effects may be a potential source of bias, it is also argued that these need not undermine the pursuit of realism²⁷⁵ as they can also help the researcher learn more about the influence of context on behaviour²⁷⁵, enhance theoretical sensitivity²⁸⁰ and allow rapport between researcher and respondents. Reflexivity on the part of the researcher – that is sensitivity to their effects on the research process – has become an essential requirement of credible qualitative research²⁸⁷. Reflexivity facilitates awareness of potential biases and allows researcher effects to be minimised, monitored and even exploited²⁷⁵ and can be achieved by open consideration of the characteristics of the

researcher²⁸⁷ and the recording and collating of 'reflective remarks' throughout the research process²²⁵.

In the context of qualitative interviewing, how one appears and presents oneself to interviewees is of crucial importance to gaining access and establishing trust and rapport³⁵². This influences the validity of the data collected, for instance, whether interviewees present 'public' (acceptable) or 'private' (real) accounts³⁰⁵. I presented myself as a research student, and survey and interview respondents appeared to relate to this well. This also removed potential barriers to open discussion about healthcare providers, for instance, one interviewee questioned if I was training to be a psychiatrist but once reassured spoke freely:

...The psychiatrist was a nightmare. (LB: In what way?) Is that what you're training to be? (LB: No, no, no don't worry, you can say what you want about psychiatrists! I don't even know any) Right, um, probably just as well actually [continues to provide lengthy critique of encounter with psychiatrist] (14: male, 18yrs)

Coupled with this student status, I sensed that my appearance as a 'young person' enhanced rapport and reduced the power differential that may occur when interviewing young people³⁵³. There was an implicit and sometimes explicit assumption by the respondents that I shared and understood their 'language' and cultural references. Rich contextualised narratives were offered naturally and without hesitation in the flow of conversation suggesting that this perceived lack of distance between myself and respondents may have added depth and set respondents at ease. One respondent directly remarked on this:

Respondent commented that she had expected someone older to turn up (to do interview). When I asked if she minded me being younger she replied that 'no, it was better' (Extract from contact sheet, interviewee 15)

It was apparent that for some 'current cases', the interview itself became or initiated an act of help-seeking decision-making. Two interviewees decided to seek help as an outcome of their interview. This was not considered problematic because it created direct access to the processes which the research aimed to discover – a situation fitting that which Hammersley and Atkinson²⁷⁵ describe as the researcher becoming the research instrument *par excellence*. There were also indications that the interview was therapeutic for some respondents, though it was important to avoid adopting the role of confidant/counsellor.

Transferability

Qualitative research strives for transferability – to suggest that what has been observed as true for the study participants, is likely to be true also to other similar people placed in similar situations^{354,355}. Achievement of this rests upon: diverse sampling (including negative cases); full description of the sample; ‘thick’ description; evidence of consistency with other studies and congruency with theory; replicability of the study; evidence that analysis has moved from description of particulars to general theory built from across the sample; and open discussion of threats to transferability²²⁵.

Maximum variation sampling was used in this study to increase the diversity of those interviewed. A range of individual characteristics, varying severities of distress, and individuals at differing points in the help-seeking trajectory and with differing help-seeking behaviours were represented. This ranged from those in the process of normalising symptoms, through those considering help-seeking or who had sought but discontinued help-seeking and were now non-help-seeking, to those receiving treatment or reflecting on past episodes. These characteristics are tabulated in Chapter 6. Attempts have been made in this chapter to triangulate with the survey data and existing literature (empirical and theoretical) and these qualitative data appear to ‘fit’³⁵⁴ well where expected within this context, thus implying external validity. An attempt has been made to derive a generalised framework of lay understandings of mental distress and a model of illness behaviour that may be applicable to adults of all ages, and contribute towards understanding young adults help-seeking behaviour in other areas such as sexual health.

It is possible that those who were willing to be interviewed were an atypical group or had particular reasons for participation, though efforts were made throughout sampling to secure interviews with low responding/hard to contact groups. Reasons for participation that became apparent were a search for information/advice, the £10 voucher given on completion, and as a step towards personal recovery. Although the sample size is relatively small (n=23), this qualitative work was embedded within a mixed methods study and, as noted, some triangulation has been possible. Further, these interviews produced rich and complex data and while it is difficult to claim data saturation, ‘researcher saturation’ did occur. Detailed time and labour intensive analysis was required to achieve a comprehensive and intelligible understanding of these data. Further examination of the robustness of the findings, particularly in relation to other

groups, and follow-up of selected interviewees should be the next step in a truly grounded approach alongside detailed exposition of negative cases.

Constructing 'non-help-seeking'

The main conceptual issue and challenge in a study of this nature is how to define the need for help. This becomes central to the interpretation of findings.

Psychiatric research typically hinges around the identification of 'cases'. This entails the dichotomisation of a continuum of mental distress into the 'normal' and 'disordered' according to an artificial threshold. Cases do not naturally occur but are an artificial category constructed by research definitions, which Prior³⁵⁰ argues are not merely technical but embedded within professional interests and assumptions, social relations and organisational needs. One need only review successive versions of the Diagnostic and Statistical Manual to appreciate the flux and expansion in clinical understandings of what constitutes mental disorder. In studies of help-seeking, caseness also defines 'need' for help on the basis of an implicit assumption that cases require treatment. The definition of caseness therefore 'constructs' the problem of non-help-seeking since the concept of a 'non-help-seeker' relies upon a concept of when help *should* be sought. It was noted in relation to other studies (Chapter 3) how variation in case ascertainment influenced prevalence estimates of help-seeking. The problem of non-help-seeking therefore can be inflated or concealed by definitions of 'caseness'.

These issues are particularly pertinent in this study, which relied upon the GHQ - a probabilistic rather than diagnostic tool - to define caseness. The prevalence of probable mental disorder (GHQ caseness) in this study was 35.4% while the prevalence of mental disorder among 16-24 year olds was estimated as 14.2% in the UK National Survey of Psychiatric Morbidity (2000)³¹. This difference probably relates to less stringent criteria and possible misclassification of mild or transient distress as caseness (below). Not all those identified as GHQ cases are likely to be suffering from disorder. The obvious question then, central to the interpretation of prevalence estimates and analyses following from these, is how meaningful and reasonable it is to imply that all GHQ cases should seek help or may benefit from doing so.

The medicalisation debate extends this question and challenges notions of non-help-seeking yet further. The helpfulness of diagnosing and treating distress as depression where patients are able to make sense of and tackle this within more normalised frames

of reference has been questioned³⁵⁶. Some authors imply that inappropriate medicalisation may be more likely in response to adolescents' and young adults' distress due to the labile nature of emotions at the age, 'normal teenage turmoil' and a dominant discourse which readily constructs young people as pathological, 'at risk' and emotionally unstable^{38,357}. It is interesting that young adults interviewed in this study appeared anxious to resist the medicalisation of young people's distress. This was evidenced in their discussion of 'depression' as a fashion that could be problematised by official labelling, and particularly in their attempts to normalise in order to avoid allowing their experience into the category of 'real' (illness) distress. Normalisation was then essentially an 'anti-medicalisation' of distress. At the same time, tension arose from these accounts. Dismissal of distress as non-genuine or as 'teenage angst' posed a problem for and constrained help-seeking and interviewees' 'anti-medicalisation' of their own distress could be pushed to extreme endpoints. The challenge therefore comes full circle, with lay people, like researchers, struggling to interpret (but also manipulating) what constitutes need.

These difficulties mean that data such as those obtained in this survey need to be presented carefully, acknowledging their 'constructedness'. This applies to qualitative data too, though it was possible to assess interviewees' likely 'need' for help in more detail by using the CIS-R and collecting detailed narratives, which sometimes included clinical diagnoses and the sample was characterised by mainly high levels of current or past morbidity. It is important to recognise that estimates of non-help-seeking include those who may or may not benefit from treatment, but equally, that 'need' for help/treatment is distinct from appropriateness of help-seeking. Whether disordered or not, GHQ cases do represent distressed and vulnerable individuals whom Goldberg and Williams suggest are *"likely to benefit from discussion of symptoms with their doctor"*²¹⁸. A focus group of GPs and psychiatrists convened during the pilot phase of this study provided evidence that healthcare professionals support such a proposition. Participants were asked to discuss the case vignettes also used in pilot interviews (Appendix 4) and the appropriateness of help-seeking, including if it was doubtful that the scenario was indicative of mental disorder. Overall, consensus was that consultation for 'distress' was appropriate.

You're asking as though we would sort of only feel it legitimate if somebody has a medical problem, a diagnosis and I, I don't think that's how most of us operate as GP's, we, we're happy to deal with distress even if its not got a

medical label. Some GP's might, might be different. I think it's entirely appropriate but we won't necessarily use a medical model (GP1: Male)

In fact, focus group participants offered several reasons why help-seeking could be important to such cases and forestall negative outcomes including harmful coping behaviours:

GP2 (female): I would want to engage them, see them again, make sure that they know that, they could, they had a person they could come and talk about stuff in case it was getting worse

GP1 (male): I agree

GP3 (male): I think the general idea that I was on their side

GP1 (male): I think that's essential, you'd want to make a definite follow up appointment

GP2 (female): And I think the thing you need to be careful about is not losing tracking of them.

These ideas lend support to the interpretation of data in this thesis and the significance of the findings obtained.

Conclusions and implications for policy and future research

This thesis has confirmed the existence of a considerable iceberg of undisclosed distress amongst young adults in the UK. This encompasses those with severe symptoms and suicidal thoughts. Only a very small proportion of young adults with mental distress seek formal healthcare and they tend to wait until distress has become extreme or chronic before doing so. Young adults' illness behaviour in response to mental distress is characterised by a cycle of avoidance in which symptoms of increasing severity are accommodated and help-seeking is replaced by attempts to 'cope' or deny illness. This cycle is frequently perpetuated by friends and family and may not be broken until the occurrence of a crisis. When help-seeking did occur this could be unstable and discontinued.

Non-help-seeking is of potential public health concern. In addition to the suffering and disability associated with untreated or unmanaged distress, the nature of the cycle suggests that non-help-seekers may be at particular risk of DSH, suicidal behaviour, and further morbidity deriving from 'unhealthy' coping strategies such as alcohol and drug misuse. Young males appear to be at particular risk due to their lower rates of help-

seeking and higher thresholds of severity for formal help-seeking. Also, early responses to distress may set a precedent for illness behaviour throughout adulthood. This thesis therefore indicates the need for intervention to improve the management of distress and an obvious way to build upon the findings is to use these as an empirical grounding from which to begin developing and piloting such an intervention. I have begun to pursue this interest as a development panel member of the Samaritans Emotional Health Promotion Strategy schools project³⁵⁸ launched in March 2004. This aims to develop a programme that will promote help-seeking and challenge stigma.

Existing responses to non-help-seeking have framed this as 'under-treatment' thus discounting illness behaviour as social action and resulting in the assumption that the problem can be tackled by removing barriers to care (usually 'access'^{121,359,360}) and improving aspects of service provision (particularly GP recognition of distress (Chapter 1))¹⁹⁴. Where lay perspectives are acknowledged these are usually treated as erroneous and indicative of poor lay mental health literacy – that is, as knowledge-based barriers that can be removed via education¹⁹⁴ (eg.³⁶¹). This thesis indicates that such approaches may be somewhat misplaced as 'barriers' were not central to understanding non-help-seeking. Access was not an issue for most interviewees and ironically attempts to make services more accessible by advertising these in school and college settings appeared to increase stigma. Interviewees also rarely cited service provision barriers though it is pertinent to note that some had encountered dismissive responses from GPs and were deterred from further help-seeking believing that young adults' distress is not respected. Further, while the data do suggest a role for education, interviewees also presented rational and reasoned arguments about the potential difficulties associated with help-seeking and any attempts to intervene should address and be responsive to these.

Interview data do draw attention to some clear areas where educational intervention may be appropriate. In particular, young adults appear to have limited understandings of the role of GPs and primary care in respect to mental health. Education could also tackle the beliefs such that: mental distress is not treatable; help-seekers will only be offered drug interventions; and young people do not suffer 'real' distress. Young adults' conceptualisations of distress and their understandings of what constitutes a 'significant' problem worthy of help could also be broadened. A role for such intervention is supported by interviewees' comments such that they were a '*first timer*' (i.d. 11), had been 'brought up' with the notion of physical illness only, or had not known how to

respond to symptoms. Also, the association between past help-seeking and current help-seeking suggests the potential to shape repertoires of response (above). It is notable however, that young adults' concerns about GPs' capacity to respond to mental distress and to provide alternatives to drug therapy appear to be mirrored by GPs^{38,362}. Interventions to promote the relevance of attending primary care would therefore need to be complemented by steps to take account of this. It is also clear that stigma needs to be tackled. Young adults feared stigma from friends, family, peers and healthcare professionals and several had experienced such a response. The stigma of mental illness is deeply rooted and has a long history³⁶³. Tackling this therefore poses a large challenge and has been the subject of recent attention in the *Lancet*^{325,363-366}, *BMJ*³⁶⁷ and several public health campaigns including the Royal College of Psychiatrists 'Defeat depression' and 'Changing minds' campaigns. Although difficult to assess, there is some evidence of positive attitude change resulting from such campaigns³⁰⁴.

However, help-seeking has emerged as a complex process guided by purposeful social action. It was not simply inability to recognise symptoms and need for help that impeded help-seeking but the social meanings attached to certain illness definitions and being a 'mental patient'. These caused interviewees to manipulate and avoid what perhaps they knew were the 'correct answers' and to resist medicalisation of distress. Stigma, for example, was a deeply entrenched and pervasive belief system, which permeated every aspect of illness behaviour and was why defining oneself as having 'real' distress and seeking help and treatment for this posed such a threat to self and social identity and was perceived as 'crossing the Rubicon'. Interactions with others, especially peers, and the social context within which young adults' distress occurred were also important aspects of this. It is too simplistic therefore to reduce the problem of non-help-seeking to a need for education. Interventions are required that can bring about normative changes to create a 'help-seeking environment' and reconstruct the social meanings of mental disorder and 'help'. The importance of this is somewhat reinforced by the finding that despite a year long Samaritans campaign corresponding with the period of data collection for this study and targeting young people²³, still less than 2% of the respondents in this study had *ever* used the Samaritans.

Interventions also need to be responsive to lay preferences and priorities. Young adults in this study appeared to favour 'non-medical' means of resolution. These are probably entirely (if not more) appropriate for mild/ self-limiting episodes of distress. While it is

important that individuals are aware of the GP as a resource that can be called upon and seek medical help where this is needed, interventions could also promote the use of a full range of help sources and supports including friends, family, and the voluntary sector, and focus on equipping young people with effective strategies for self-management and self-help, as interviews suggest that the coping strategies currently adopted by young people are more to do with denial and avoidance than resolution.

Further research needs to be directed towards the challenge of developing the content and delivery of such interventions and the piloting of these. Given that peers take part in normalising, perpetuate stigma and thus contribute towards creating a 'non-help-seeking' environment, intervention might be most effective if peer-led. The indication that amongst adolescents negative coping strategies such as deliberate self-harm may be learnt from peers²² lends further weight to the possibility of using peers to disseminate more positive coping strategies. A particular challenge lies with arriving at an outcome measure that can be used to assess effectiveness.

Further research could also explore the transferability of the understanding of illness behaviour derived in this thesis. For instance, whether this applies also to help-seeking in other age groups for mental distress and also in response to other types of symptom. The potential for wider application of these findings beyond the understanding of help-seeking should also be explored. They may also be of relevance to other stigmatising conditions and wider illness behaviours such as acceptance of diagnoses and compliance with treatment.

Appendix 1: Pilot study recruitment letter

(On Practice headed paper)

Date' 00

Dear X,

I am writing to you about a research project that I am currently working on with researchers from the University of Bristol. We are investigating psychological health in young adults and the sources of help young people can turn to in times of stress and crisis.

A researcher, Lucy Biddle, would like to talk to some people of your age group to find out about their views and experiences. We have used our practice patient lists to randomly select a group of people and your name is one of those that has been selected. I am therefore writing to ask if you would be willing to spare a short amount of time to meet with Lucy. I would like to emphasise that anything you were to discuss with Lucy will remain confidential and neither your name nor details will be reported in any research papers or linked to the information you provide us.

We would appreciate your help with this study, but, participation is voluntary and you are under no obligation to take part. I am enclosing a study information sheet, which explains more about the project. If you have any further questions about the study please use the *University contact number* shown on the information sheet.

At the bottom of this page is a reply slip. We would be grateful if you could indicate whether or not you are willing to take part by filling it in and returning it to the University in the envelope provided.

We look forward to hearing from you and hope that you will be able to spare the time to help with this project.

Yours sincerely,

Dr. X

.....

REPLY SLIP: YOUNG PEOPLE, PSYCHOLOGICAL HEALTH AND STRESS STUDY

Name: Address

1. Please TICK as appropriate: ☐ I am willing to be interviewed for the above study
☐ I am *not* willing to be interviewed for the above study

2. If willing to be interviewed, please indicate how you can be contacted:

My number is

The best times to ring are:

3. If you would rather not take part it would be helpful if you would use the reverse of this slip to tell us why. However, you are not in anyway obliged to do so.

Appendix 2: Pilot study information sheet

(On University headed paper)

STUDY INFORMATION SHEET – Version 1, September 2000

YOUNG PEOPLE, PSYCHOLOGICAL HEALTH AND STRESS STUDY

What is the Study about?

Young adulthood can be a stressful time with many pressures, changes and personal difficulties, all of which can have a bad effect on psychological health and lead to depression. However, people are often reluctant to seek help for these sorts of problems. This study aims to find out about young people's experiences: - how they deal with problems and what might stop them from seeking help if they need it

Why is the study important?

The findings from this study may go towards improving services for young people by making them more appropriate and accessible.

Why have I been chosen?

We did not particularly 'choose' you. To ensure that we speak to a variety of people, we randomly selected names from the list of people aged 16-24 who are registered at your GP practice. By chance, your name was one of those that came up.

What if I haven't had any problems or stress?

It doesn't matter. We would like to talk to people regardless of whether or not they have suffered from any stress so that we can get a wider variety of views.

What will I have to do if I take part?

I will contact you to arrange a convenient time that we could meet. When we meet I would like to interview you. This will only take about 45 minutes. I will start by giving you a short questionnaire to fill in and then we will talk for a while about your own views, thoughts and experiences on the topic. I will be happy to come to your home to see you, or, if you prefer, we could meet at the University. I would also like to tape-record the interview, but only if you are agreeable. Tapes will be destroyed at the end of the study.

Will the interview be confidential?

Full confidentiality is guaranteed at all stages of the interview and no one - including your GP - need know that you have taken part. Any information you supply will be made anonymous. Not even your GP will have access to it.

Do I have to take part?

No - participation is voluntary and you are free to refuse without giving a reason. I can also assure you that refusal will not effect your chances of obtaining medical services now or in the future.

Thank you for reading this information. I would appreciate it if you would give the matter serious consideration and then return the reply slip in the envelope provided as soon as possible. If you have any questions or would like to discuss the study further please do not hesitate to contact me on 0117 9287395 or by e-mail at lucy.biddle@bristol.ac.uk.

Appendix 3: Consent form used in pilot and main study interviews

(On University headed paper)

INTERVIEW CONSENT FORM

Investigating Psychological Health And Stress During Young Adulthood – Experiences Of Distress And Seeking Help.

Please complete the following form carefully, circling answers as appropriate.

Have you read the Study Information Sheet?	Yes/ No
Have you been able to ask questions and discuss the study?	Yes/ No
Have you received satisfactory answers to all your questions?	Yes/ No
Have you received enough information about the study?	Yes/ No
To whom have you spoken?	

Do you understand that you are free to withdraw from the study:

- At any time? Yes/ No
- Without having to give a reason? Yes/ No
- Without this effecting your future medical care? Yes/ No

Do you agree to take part in the study?	Yes/ No
Do you agree to the use of audio tape recording at the interview?	Yes/ No

Signed..... Date.....

Name in block letters.....

Signed (Researcher)..... Date.....

Name in block letters.....

Researcher contact number: 0117 9287395

Appendix 4: Case vignettes

1: ALEX

Everything is getting on top of Alex who feels like escaping from it all. There seem to be so many problems: - study, relationships, family.... Alex is desperate to get good exam grades but can't concentrate anymore. Alex lays awake each night worrying about things and then when morning comes around feels unable to face the day.

Break here

Everything seems hopeless and bad thoughts constantly fill Alex's mind and slow things down. Even things that used to make Alex happy don't anymore. Alex is scared because sometimes things feel so bad life seems not worth living.

Break here

Alex wants some help, and someone to talk to, but doesn't know who to go to.

2: CHRIS

Chris has been getting really stressed out about things lately and is unhappy and moody. Chris can't concentrate at work, gets really impatient with the new baby and has been drinking more alcohol lately than is usual.

Break here

Chris thinks something is not quite right and decides to go to the doctor who suggests talking to a counsellor might help but Chris is worried about what friends might think if they found out and so does not know whether to go.

Break here

Chris decides not to bother seeing the counsellor.

3: PAT

Pat keeps getting bad headaches and nearly always feels tired. Often Pat's muscles ache too and all Pat feels like doing is lying in bed. Pat doesn't feel very happy either and often gets tearful for no particular reason. Now Pat has started to lose weight.

Break here

Pat decides to make an appointment to see the doctor.

4: SAM

Sam has only been out with friends a couple of times over the last few weeks. They can't understand this because Sam has always been the life and soul of the party. In fact, things haven't been quite the same since they left college and began looking for jobs. Sam, like some of the others, has as yet been unable to find a job. Sam's parents have also been concerned because they can't motivate Sam to do anything any more. Sam often won't get up in the morning, misses meals and doesn't really seem to care about anything or anyone.

Break here

Sam decides to go to the doctor. The doctor gives Sam antidepressant tablets.

Appendix 5: The study questionnaire

PSYCHOLOGICAL HEALTH QUESTIONNAIRE

Confidential

Life can be stressful with many pressures that may affect psychological health. We are trying to find out more about the experiences of young people and would be extremely grateful if you would take the time to complete this questionnaire. Please fill it in even if you haven't experienced any psychological or emotional problems because your views are still important. It will only take about 15 minutes to complete and all your answers will be kept strictly confidential. When you have completed the questionnaire, please return it in the postage paid envelope provided. You do not need a stamp. Please try to answer all the questions, however, if you are unable to fully complete the questionnaire please *still* return it.

If you have any difficulties filling in the questionnaire, or wish to ask any questions, we will be glad to help you. Please contact us on one of the following numbers:

Lucy Biddle:	0117 9287395
Sarah Polack:	0117 9287324

Thank you!

Lucy

About Yourself

1. Please write: (a) your age years
 (b) your date of birth day month year

2. Are you male or female? (Please tick) ☐¹ Male ☐² Female

3. Who do you live with? (Tick all that apply)	Yes ¹	No ²	For office use
(a) Parent(s)	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Friends	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Partner/ Spouse	<input type="checkbox"/>	<input type="checkbox"/>	
(d) Brother/ Sister	<input type="checkbox"/>	<input type="checkbox"/>	
(e) Alone	<input type="checkbox"/>	<input type="checkbox"/>	
(f) Other (please explain below)	<input type="checkbox"/>	<input type="checkbox"/>	
..... ²			

4. Which of the following describe what you do?	Yes ¹	No ²	
(a) Employed full-time	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Employed part-time	<input type="checkbox"/>	<input type="checkbox"/>	
(c) In full-time study or training	<input type="checkbox"/>	<input type="checkbox"/>	
(d) In part-time study or training	<input type="checkbox"/>	<input type="checkbox"/>	
(e) Unemployed	<input type="checkbox"/>	<input type="checkbox"/>	
(f) Looking after house or family	<input type="checkbox"/>	<input type="checkbox"/>	
(g) Other (please explain below)	<input type="checkbox"/>	<input type="checkbox"/>	
..... ²			

5. In general, how would you rate your health? (Please tick one box only)

☐¹ ☐² ☐³ ☐⁴ ☐⁵
 Excellent Very Good Good Fair Poor

6. Approximately how many times in the last year have you been to see a GP for any problems with your health or well-being?

☐¹ ☐² ☐³ ☐⁴
 None 1 or 2 3 or 4 5 or more

PTO

About Your Feelings

7. We would like to know how you have felt in general over the past few weeks.

Please answer all the questions by circling the most appropriate answer for each question. Please circle one answer per question only.

HAVE YOU RECENTLY:		1	2	3	4
(a)	Been able to concentrate on whatever you are doing	Better than usual	Same as usual	Less than usual	Much less than usual
(b)	Lost much sleep over worry	Not at all	No more than usual	Rather more than usual	Much more than usual
(c)	Felt that you were playing a useful part in things	More so than usual	Same as usual	Less than usual	Much less useful
(d)	Felt capable of making decisions about things	More so than usual	Same as usual	Less so than usual	Much less capable
(e)	Felt constantly under strain	Not at all	No more than usual	Rather more than usual	Much more than usual
(f)	Felt that you couldn't overcome your difficulties	Not at all	No more than usual	Rather more than usual	Much more than usual
(g)	Been able to enjoy your normal day-to-day activities	More so than usual	Same as usual	Less so than usual	Much less than usual
(h)	Been able to face up to your problems	More so than usual	Same as usual	Less able than usual	Much less able
(i)	Been feeling unhappy and depressed	Not at all	No more than usual	Rather more than usual	Much more than usual
(j)	Been losing confidence in yourself	Not at all	No more than usual	Rather more than usual	Much more than usual
(k)	Been thinking of yourself as a worthless person	Not at all	No more than usual	Rather more than usual	Much more than usual
(l)	Been feeling reasonably happy, all things considered	More so than usual	About the same as usual	Less so than usual	Much less than usual
(m)	Felt that life is entirely hopeless	Not at all	No more than usual	Rather more than usual	Much more than usual
(n)	Felt that life isn't worth living	Not at all	No more than usual	Rather more than usual	Much more than usual
(o)	Found yourself wishing you were dead and away from it all	Not at all	No more than usual	Rather more than usual	Much more than usual
(p)	Found the idea of taking your own life kept coming into your head	Definitely not	I don't think so	Has crossed my mind	Definitely has

For
office
use

☐

Q

8. The previous questions asked you to consider your usual state of psychological health. Overall, how would you rate your usual psychological health?

☐₁ Good
 ☐₂ Okay
 ☐₃ Poor
 ☐₄ Very Poor

9. Do you feel as though you are suffering from psychological or emotional problems at the moment?

Yes ☐₁ No ☐₂

10. (a) Are you taking any medicine or tablets for psychological or emotional difficulties at the moment (including anti-depressants, herbal remedies etc)?

Yes ☐₁ *Please continue* No ☐₂ *Go to question 11*

- (b) ¹What are you taking?

.....

- (c) ¹Whose idea is this? (e.g. yours, your doctor's)

.....

For office use

b2 ☐

c2 ☐

11. (a) Have you ever suffered from psychological or emotional problems?

Yes ☐₁ *Please continue* No ☐₂ *Go to question 12*

- (b) How long ago was this? (If there has been more than one occasion choose the most significant)

☐₁ In last 12 months
 ☐₂ 1 - 2 years
 ☐₃ 3 - 4 years
 ☐₄ 5 or more years

12. (a) Have you ever taken any medicine or tablets for psychological or emotional difficulties in the past (including anti-depressants, herbal remedies etc)?

Yes ☐₁ *Please continue* No ☐₂ *Go to question 13*

- (b) ¹What did you take?

.....

- (c) ¹Whose idea was this? (e.g. yours, your doctor's)

.....

b2 ☐

c2 ☐

PTO

About Getting Help

13. (a) In the past, have you ever sought any help or advice for a psychological or emotional problem (for example from friends, family or a doctor)? Please tick one box only.

No – I have not needed to

☐ ₁

No – but I think perhaps I should have done

☐ ₂

Go to question 14

Yes

☐ ₃

Please continue

(b) Which of the following people have you sought help from in the past for a psychological or emotional problem? *(Please tick as many as apply)*

	Yes ¹	No ²
(1) Doctor (GP)	<input type="checkbox"/>	<input type="checkbox"/>
(2) Family	<input type="checkbox"/>	<input type="checkbox"/>
(3) Friend	<input type="checkbox"/>	<input type="checkbox"/>
(4) Teacher/ Tutor/ Employer	<input type="checkbox"/>	<input type="checkbox"/>
(5) Self-help or voluntary group	<input type="checkbox"/>	<input type="checkbox"/>
(6) The Samaritans	<input type="checkbox"/>	<input type="checkbox"/>
(7) Other telephone helpline	<input type="checkbox"/>	<input type="checkbox"/>
(8) Counsellor	<input type="checkbox"/>	<input type="checkbox"/>
(9) Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>
(10) Other (please explain in the space below)	<input type="checkbox"/>	<input type="checkbox"/>

.....

(c) ¹ Why did you decide to seek help at that time?

.....
.....
.....
.....

For
office
use

11 ☐

c2 ☐

14. (a) Have you sought any help or advice for a psychological or emotional problem in the last four weeks (for example from friends, family or a doctor)? Please tick one box only.

No – I have not needed to

☐ ¹

No – but I think perhaps I should have done

☐ ²

Go to question 15 (below)

Yes

☐ ³

Please continue

(b) Which of the following people have you sought help from for a psychological or emotional problem in the last four weeks? (Tick as many as apply)

	Yes ¹	No ²
(1) Doctor (GP)	<input type="checkbox"/>	<input type="checkbox"/>
(2) Family	<input type="checkbox"/>	<input type="checkbox"/>
(3) Friend	<input type="checkbox"/>	<input type="checkbox"/>
(4) Teacher/ Tutor/ Employer	<input type="checkbox"/>	<input type="checkbox"/>
(5) Self-help or voluntary group	<input type="checkbox"/>	<input type="checkbox"/>
(6) The Samaritans	<input type="checkbox"/>	<input type="checkbox"/>
(7) Other telephone helpline	<input type="checkbox"/>	<input type="checkbox"/>
(8) Counsellor	<input type="checkbox"/>	<input type="checkbox"/>
(9) Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>
(10) Other (please explain in the space below)	<input type="checkbox"/>	<input type="checkbox"/>

For office use

.....

11 ☐

(c) ¹ Why did you decide to seek help at this time?

.....
.....
.....
.....

c2 ☐

15. (a) Have you ever not sought help for a psychological or emotional problem when you think you should have done or would like to have done?

Yes ☐ ¹

No ☐ ² Go to Question 16

(b) ¹ Why didn't you seek help?

.....
.....
.....
.....

b2 ☐

About Friends and Family

16. Below is a list of things that others do for us or give us that may be helpful or supportive. Please read each statement carefully then circle the number on a scale of 1 to 5 that is closest to your situation - where '1' means 'Much less than I would like' and where '5' means 'As much as I would like'.

I GET	Much less than I would like	Less than I would like	Some of the time	Almost as much as I would like	As much as I would like
(a) Invitations to go out and do things with other people	1	2	3	4	5
(b) Love and affection	1	2	3	4	5
(c) Chances to talk to someone about work/ study problems	1	2	3	4	5
(d) Chances to talk to someone I trust about personal/ family problems	1	2	3	4	5
(e) Chances to talk about money matters	1	2	3	4	5
(f) People who care what happens to me	1	2	3	4	5
(g) Useful advice about important things in life	1	2	3	4	5
(h) Help when I am sick	1	2	3	4	5

17. Think about which of your parents has been your family's main wage earner. Please give details of this parent's main occupation - i.e. the occupation that they have spent the greatest part of their working life in.

(a) What was/ is this parent's job title (e.g. butcher, accountant)?
.....

(b) What were/ are the main things done in this job?
.....

(c) Was/ is the job full time or part time? ☐ Full time
 (30 + hours a week)

☐ Part time
(Under 30 hours a week)

(d) Which one of the following best describes their position at work? (tick one box only)

<input type="checkbox"/> Employee	<input type="checkbox"/> Self employed (with employees)	<input type="checkbox"/> Self employed (no employees)
--	---	---

(e) Did/ do they supervise anyone?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

And Finally – A Short Story

18. Please read this short story about 'Alex' and answer the questions that follow.

PART A:
Everything is getting on top of Alex who feels like escaping from it all. There seem to be so many problems: study/ work, relationships, family. Alex is desperate to do well but can't concentrate on anything anymore. Alex lays awake at night worrying about things and when morning comes around feels unable to face the day.

(1) If you were Alex, what (if anything) would you think was wrong with you?

(2) What do you think Alex should do about these feelings?

Yes¹

No²

(a) Nothing

☐

☐

(b) Wait to see what happens

☐

☐

(c) Try going out and doing new things

☐

☐

(d) Speak to family and/or friends

☐

☐

(e) Go to a doctor

☐

☐

(f) Other (please explain below)

☐

☐

(3) What do you think Alex will do?

For
office
use

b

a

b

PART B:
Everything seems hopeless and bad thoughts constantly fill Alex's mind and slow things down. Even things that used to make Alex happy don't anymore. Alex is scared because sometimes things feel so bad that life seems not worth living.

(1) If you were Alex, what (if anything) would you think was wrong now?

(2) What do you think Alex should do now?

(3) What do you think Alex will do?

b

b

b

PTO

7

337

Alex Continued....

PART C: Some questions about both parts	
(1) Did you think Alex was male or female?	<input type="checkbox"/> ₁ Male <input type="checkbox"/> ₂ Female
(2) * Why did you think this?	<div>.....</div> <div>.....</div> <div>.....</div> <div>.....</div> <div>.....</div>
(3) Have <u>you</u> ever felt at all like Alex?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
(4) * If yes, what did you do about the way you were feeling?	<div>.....</div> <div>.....</div> <div>.....</div> <div>.....</div> <div>.....</div> <div>.....</div> <div>.....</div> <div>.....</div> <div>.....</div> <div>.....</div>

Consent Statement

Please read the following and sign:

This information will be held and processed for *research*. The information will be kept confidential and not passed to anyone else. It will not be possible to identify you in any findings.

'I agree to the University of Bristol recording and processing this information about me. I understand that this information will be used only for the purposes set out in the statement above, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act'.

Signature	Date.....
-----------------	-----------

<p>THANK YOU FOR TAKING TIME TO FILL OUT THIS QUESTIONNAIRE.</p> <p>NOW PLEASE RETURN IT IN THE PRE-PAID ENVELOPE PROVIDED.</p> <p>NO STAMP IS NEEDED.</p>

Please still return the questionnaire even if you have not answered all the questions.

Name (Block Capitals):
Address:
Postcode

Space for Further Comments

If there is anything else you would like to tell us, or any comments you would like to make – please use this space to do so.

Appendix 6: Covering letter sent with questionnaire in survey

(On University headed paper)

Date

Dear

The enclosed questionnaire is part of a University of Bristol research study into young people’s experiences of stress and psychological ill-health. I hope you can spare the 15 minutes it will take to complete this. This will allow your experiences and views to be represented in the study. When you have finished the questionnaire please return it to me in the envelope provided. No stamp is needed.

Your name was one of 3000 that Avon Health Authority randomly selected from its population register to receive this questionnaire. No personal information about you, including your address, has been disclosed to me. This letter and questionnaire have been forwarded to you by the Health Authority. I can guarantee that any information you give will remain entirely confidential and neither your doctor nor the Health Authority will have access to it. Participation in this survey is voluntary and you can refuse without giving a reason. Should you decide not to take part I can assure you that this decision will not affect your chance of obtaining medical services now or in the future.

If you do not wish to take part, I would be grateful if you would return the uncompleted questionnaire to me in the envelope provided for the purposes of monitoring. You do not have to give a reason for refusal but please feel free to do so if you wish when returning the blank questionnaire.

A small number of responders may be asked to discuss their views further by participating in an interview. Once again, this would be entirely voluntary.

If you have any questions that you would like to ask before completing the questionnaire, please phone either myself on 0117 9287395 or Sarah Polack on 0117 9287324 and we will be pleased to help. Alternatively, you could e-mail me at lucy.biddle@bristol.ac.uk.

I am hoping that the research will go towards improving services for young people. Your help with this is greatly appreciated.

Many thanks.

Yours Sincerely,

Lucy Biddle

Appendix 7: Reminder postcard sent to survey non-responders (1st reminder)

PSYCHOLOGICAL HEALTH QUESTIONNAIRE

Recently, you were invited to take part in a study by completing a questionnaire about psychological health. We are yet to receive your completed questionnaire. Your views and experiences are important to this study and will remain entirely confidential. I will be pleased to send you another copy of the questionnaire if you have mislaid the original. If however you have decided not to fill it in, please return the blank form in the envelope provided and we will not trouble you again.

If you have recently posted your questionnaire, please accept my thanks and ignore this postcard. Avon Health Authority have forwarded this card to you on my behalf.

Yours faithfully,

Lucy Biddle,

Department of Social Medicine, University of Bristol, Canynge Hall, Whiteladies Road, BRISTOL, BS8 2PR. Tel: 0117 9287395

Appendix 8: Reminder letter sent with second issue of the questionnaire to non-responders (2nd reminder)

(On University headed paper)

Date

Dear

A few weeks ago I invited you to take part in a study about psychological health by filling in a short questionnaire. You were one of a number of people chosen at random to take part. I have not yet received your returned questionnaire - completed, or blank. If you have recently posted it, please ignore this letter and accept my thanks.

In case you did not receive the questionnaire, or have since mislaid it, another copy has been enclosed in this envelope which is being forwarded to you by Avon Health Authority. It will only take a short while to complete and can be returned in the freepost envelope also provided – no stamp is needed. Please try to answer all the questions, however, if you are unable to fully complete the questionnaire please *still* return it.

I would like to emphasise that any information you supply will be treated in the strictest of confidence and not even the health Authority will have access to it. Your views and experiences are important to this study and I will sincerely appreciate your help. I am hoping that the research will go towards improving services for young people.

If, however, you have decided not to complete the questionnaire please still return the blank form so that I can update my records. You do not have to give a reason for refusal but please feel free to do so if you wish.

If you have any questions regarding the study or the questionnaire, please do not hesitate to contact me on 0117 9287395.

Yours Sincerely,

Lucy Biddle.

Researcher

Appendix 9: Interview recruitment letter

(On University headed paper)

Date _____

Dear X

Recently, you kindly filled out a questionnaire to help me with my research into the psychological health of young people. I now want to collect some more detailed information and am hoping you will agree to help me again.

I would like to interview you so that I can find out more about your views and experiences. I am enclosing an information sheet so that you can read some more about the study and what being interviewed would involve. I hope that this information will help you decide. However, if you would like to discuss the study further or ask more questions before deciding, please do not hesitate to contact me on the number shown on the information sheet.

I really would appreciate your help, however, participation is voluntary and you are under no obligation to agree. I would like to emphasize that the interview would be strictly confidential and neither your name or details would be reported in any research papers or linked to the information you provided.

At the bottom of this page is a reply slip. I would be grateful if you could indicate whether or not you are willing to participate by filling it in and returning it in the envelope provided.

I look forward to hearing from you and hope you will be able to spare the time to talk to me.

Yours sincerely,

Lucy Biddle

REPLY SLIP: YOUNG PEOPLE AND PSYCHOLOGICAL HEALTH STUDY

1. Please tick as appropriate:
- ☐ I am willing to be interviewed for the above study
- ☐ I am *not* willing to be interviewed for the above study

If you would rather not take part it would be helpful if you would use the space overleaf to tell me why. However, you are not in anyway obliged to do so.

- 2. If willing to be interviewed, please indicate how you can be contacted:**

My telephone number is

The best times to ring are:.....

If you can't be reached by telephone, please state how we can contact you

.....

Appendix 10: Information sheet for interviewees

(On University headed paper)

STUDY INFORMATION SHEET – Version 2, March 2001

YOUNG PEOPLE, EMOTIONAL HEALTH AND HELP SEEKING

What is the Study about?

Life can be stressful with many pressures and problems that can have a bad effect on psychological health leading to stress or depression. However, people are often reluctant to seek help. This study aims to find out about young people's experiences: - how they deal with problems and what might stop them from seeking help if they need it.

Why is this Study important?

The findings from this study may go towards improving services for young people by making them more appropriate and accessible.

Who is involved in the Study?

The research is being carried out by a team of researchers at the University of Bristol. The project is partly funded by NHS research funds. The research has been approved by regional Ethics Committees.

Why have I been chosen?

We did not particularly 'choose' you. To ensure that we speak to a wide variety of people, 3000 young people aged 16-24 were randomly selected from all of those included on Avon Health Authority's population register. All 3000 people were sent a question. By chance, your name was one of those that came up and you will remember recently completing the study questionnaire and returning it to me. So that I can find out some more detailed information, I have now selected a further group of people from those who returned the questionnaire and whose answers suggested that either now or in the past they may have suffered from some problems. I am hoping to talk to about 40 people altogether. Once again your name has been selected.

What if I haven't had any problems or stress?

It doesn't matter. I would like to find out the views of a wide variety of people, regardless of whether or not they have experienced psychological ill-health.

What will I have to do if I take part?

I will contact you to arrange a convenient time that we could meet for an interview. The interview should only take about 60 minutes. I would like to talk to you about your own thoughts on feeling stressed and unhappy and how easy you think it is to get help if you feel that way. I plan to hold the interviews in a private room at the University. However, if you would find this difficult I could make arrangements to come to your home. I would like to tape record the interview, but would only do so if you were agreeable. At the end of the interview, I would like to give you a £10 voucher as a token of my thanks for your help and to cover any expenses.

Will the interview be confidential?

Full confidentiality is guaranteed at all stages of the interview and no one need know that you have taken part. Any information you supply will be anonymised and neither your doctor nor the Health Authority will have access to it. Nothing that you say will be personally identified in any reports that are produced on the basis of this research. At the end of the study any tapes that have been made of your interview will be destroyed.

How can I find out the results of the Study?

If you would like to receive a summary of the Study findings this can be arranged at the interview and they will be forwarded to you as soon as they are available.

Do I have to take part?

No - participation is voluntary and you are free to refuse without giving a reason. I can also assure you that refusal will not effect your chances of obtaining medical services now or in the future.

I hope that this information answers any question you might have, however, if there is anything you would like to discuss further please do not hesitate to contact me on 0117 9287395 or by e-mail at lucy.biddle@bristol.ac.uk. Thank you for reading this information and considering taking part in the study. I would appreciate it if you would return the reply slip in the envelope provided as soon as you have made a decision. Please be assured that your views and experiences are important to this study and I will sincerely appreciate your help.

Appendix 11: Final interview topic guide

CONCEPTS

Health and illness
Mental/ psychological distress
Mental illness
'Types' of Depression
Distress in young people

Recognition/ cause

Normal v. abnormal
Difficulties
Susceptibility
'Problems'

Help

What help and when?
Triggers/ symptoms
Who seeks help? Prevalence?

ILLNESS NARRATIVE

History and context
Symptoms
Help-seeking (past/ current)

Lay diagnosis

Seriousness/ meaning of sympts
Definition
Explanation/ cause
Expected outcomes

Illness behaviour

Need for help? When?
Coping v. help-seeking
Why try to cope alone?
Recognising not coping

HELP-SEEKING

Beliefs

Does help work?
Is mental distress treatable?

Meanings of Help

Reasons for n-h-s
Benefits of help?
Fears/ expected consequences
Why resist?
Seriousness?
Identity

Barriers

Gender
Stigma/ Weakness
Knowledge
Practical (access)

HELP-SEEKING OPTIONS

Available sources
Preferred option
Type of help wanted
Responses to young people
Experiences of help
A role for 'medical' help?

The lay group

Availability
Talking about distress
Peers
Family
Reasons for non-disclosure

Appendix 12: Help services information sheet for interviewees

LOCAL HELP SERVICES

Connections

Provides information and contact numbers of local Health and Social Care help services in Bristol. They will search their register for the type of service that you need.

Tel: 0117 9585522 (Weston-Super-Mare: 01934 820104)

Address: The Care Forum, The Vassall Centre, Gill Ave. Fishponds, Bristol BS16 2QQ

The Samaritans - Bristol

Telephone Crisis line and drop-in centre

Tel: 0117 9831000 08457 909090 (24 hr National Line)

Address: 37 St. Nicholas Street, Bristol, BS1

Off the record

Free Information, advice and counselling for young people

Tel: 0117 9279120

Address: 2 Horfield Road, St. Michaels Hill, Bristol

Bristol Mind

Helpline, drop-in and information to support those in mental or emotional distress and with mental health problems, including depression and anxiety.

Tel: 0117 9830330

Address: PO Box 1174, Bristol, BS99 2PQ.

Saneline

Out of hours helpline offering advice and support

Tel: 0845 7678000

Womankind

Counselling and Therapy Centre

Tel: 0117 9252507

Address: 76 Colston Street, Bristol, BS1 5BB

Appendix 13: Letter to GP issued for use by distressed interviewees

(On University headed paper)

Date:

Dear Doctor,

Your patient Mr/Mrs/Ms/Miss has recently taken part in a study about psychological health and stress undertaken by researchers at Bristol University.

The study involved a postal questionnaire and interview which included the following measures of psychiatric morbidity: The General Health Questionnaire (GHQ-12) and the Clinical Interview Schedule Revised Version (CIS-R). At the end of the interview, I suggested to your patient that he/she might like to contact you since it appeared that they might be suffering from psychological symptoms which would benefit from treatment. I have issued your patient with this letter to be handed to you at their own discretion should they subsequently decide to consult with you.

If you have any questions please contact me on: 0117 9287395.

Yours faithfully,

Lucy Biddle.

Appendix 14: Sample contact sheet used in qualitative analysis

Respondent characteristics:

Ref: 1.124

Batch: 1

Date of interview: 20/03/01

Date of questionnaire: 19/01/01

Interview location: Canynge Hall

Gender: Male

Age: 21

Measures of caseness:

GHQ score 1: 10

GHQ score 2: Not conducted

CIS-R score: Not conducted

Chronic case? No

DSH? No

Suicidal ideation? No

Diagnosis: Depression
(offered by interviewee)

Case and help-seeking status: Past case (survey duration), Lay only help-seeking

Brief summary of illness narrative: Described an episode of depression for which he could suggest no specific cause. The episode lasted approx 2 – 3 months.

Brief summary of illness behaviour: Spoke to family when they confronted him having noticed a change in his mood/ behaviour. He was not prepared to seek help from GP. Described himself as relatively helpless and perceived depression as something that could not be controlled like physical illnesses. Eventually the depression lifted - he is not sure how.

Research questions covered most centrally:

- Barriers to help-seeking and reasons for non-help-seeking – esp. stigma, privacy
- Evaluation of the Doctor as a source for psychological help
- The lay group as an alternative/ preferred source for help/ source

Main Issues Arising:

1. A new and strange experience he couldn't explain. This made it difficult to talk about and to know how to respond to. Felt need to explain 'why' to self and others.
2. Different perception of psychological illnesses: lack of control or knowledge over the trajectory, helplessness – not a lot can be done, don't know when it will end.
3. Didn't consider doctor an option because didn't have personal relationship and trust- therefore didn't think could help.
4. Felt a lack of options re: help sources.
5. Social attitudes/ social meanings of help-seeking were a deterrent to seeking help – e.g. stigma, sign of weakness, admission that there is a problem.
6. Depression as a private matter - therefore a desire to sort it out individually and not reveal it to others, inc. the doctor.
7. Perceives seeking help from doctor as a pivotal thing – sign of seriousness, makes more real, makes more long term (esp. drug taking).

Thoughts, hunches and possible new hypothesis:

- A diagnosis 'depression' and treatment is not seen as appropriate. People search for a reason and a solution – traditional medical model does not fit.
- Need a language of 'cause' to making talking about feeling down/ depression acceptable
- Seeking (medical) help for depression linked to severity and would constitute a major new aspect of the biography. Is not telling people or seeking help an attempt to keep hold of normality?
- Seeking help is what re-define the experience?
- There is an apparent fatalism about depression – uncontrollable illness with no 'cure'

Direction/ questions for next interviewee:

1. Are medics able to treat/ control depression and specify a trajectory?
2. Why is it important to know cause? How does experience vary for those do/ do not?
3. Why carry the burden of trying to overcome it before seeking help as a last resort?
4. Explore how 'treatment' for mental perceived differently to 'treatment' for physical
5. What does the fear of making a first move to talk to others actually consist of?
6. Is it important to have a personal relationship with help sources and why?

Appendix 14 cont. Sample contact sheet used in qualitative analysis

7. Why is depression a private matter? And why the desire to hide from others
8. Why does it need to be so severe before seeking help? Would they leave physical illnesses to this level of severity?
9. What do they think would happen after seeking help? feelings about self, others reactions, the course of the illness?

Fieldwork comments about the contact:

- Interview comfortable and went smoothly
- Gave thoughtful/ honest answers clearly linked to his experiences.
- Difficult to assess episode due to time lapse between questionnaire & interview.
- As a retrospective account though this worked quite well.

Appendix 15: Summary of themes relating to interviewees perceptions of help sources

	<i>Appropriateness</i>	<i>Evaluation of help provided</i>	<i>Meanings/ consequences of help-seeking</i>
GP	LOW <ul style="list-style-type: none"> Deal with physical problems only Deal with 'illness' only (not non-illness mental distress, or personal problems) Lack training, knowledge or skill to treat/ understand mental distress Constrained by medical model which is incompatible with mental distress 	LIMITED <ul style="list-style-type: none"> Cannot provide the type of help needed for mental distress – listening, talking and problem-solving Can only offer medication (undesirable) or referral (helpful) 	<ul style="list-style-type: none"> Dismissive response to those consulting with mental distress/ personal problem Initiates status passage into 'real' distress Likely to result in medication and negative meanings associated with this
Medication	LOW <ul style="list-style-type: none"> Can 'cure' physical problems but cannot solve mental distress/personal problems May prolong distress Reluctance to intervene with the mind 	LOW <ul style="list-style-type: none"> Will not solve the problem Associated with a number of negative outcomes: addiction, reliance, side effects 	<ul style="list-style-type: none"> Associated with seriousness/ sign of 'real' distress Sign of weakness and inability to cope Provoke stigma of 'mental illness'
Counselling	HIGH <ul style="list-style-type: none"> Specialists in 'problems' and 'the mind' Have skills and training comparable to psychiatrists/ psychologists Provide 'type of help' required for mental distress 	HIGH (hypothetical) - LIMITED (actual) <ul style="list-style-type: none"> Provide listening, talking and problem-solving help Can offer advice Can explore feelings/identify causes Acts as confidant 	<ul style="list-style-type: none"> Sign of weakness Cause embarrassment Provoke stigma of 'mental illness' or accusation of being ungenueine Stigma linked to context of peers and school/ college services
Samaritans	LIMITED <ul style="list-style-type: none"> For very extreme distress and problems only ('real' distress and 'freaks') 	LOW <ul style="list-style-type: none"> Remote, impersonal service Passive 'help' Momentary and lacks continuity 	<ul style="list-style-type: none"> Provides possible opportunity to seek help anonymously and so without repercussions.
Friends and family	HIGH <ul style="list-style-type: none"> A first option Appropriate also for 'normal' distress 	MIXED (situational) <ul style="list-style-type: none"> Personal and genuine approach Can provide listening, problem-solving, practical help and advice, comfort, support and distraction But, may make problem worse, be unable/ unwilling to help, or be burdened 	<ul style="list-style-type: none"> Often dismissive May suggest distress is ungenueine May stigmatise the help-seeker

Appendix 16: Pictures drawn by respondents on questionnaires

Space for Further Comments

If there is anything else you would like to tell us, or any comments you would like to make, please use this space to do so



Appendix 16 cont. Pictures drawn by respondents on questionnaires

Space for Further Comments

If there is anything else you would like to tell us, or any comments you would like to make – please use this space to do so.



FOR ANYONE WHOSE JOB IT IS
TO HELP OTHERS GENUINE HEARTFELT
COMPASSION, EMPATHY, SYMPATHY ARE
NEEDED, ALONG WITH THE ABILITY TO NOT
JUST HEAR, BUT RALLY LISTEN.

DON'T JUST GIVE THE SAME TEXTBOOK
ANSWERS, AND DON'T JUST PRESCRIBE PILLS
AS IF IT WERE, EENIE, MEENIE, MINEE MO,
WHICH ALL SHAL WE GIVE A GO.

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